Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:00 Joseph David Greenberg Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Agrus HUSPITAL Baltimore 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 048-30-7928 **Director** 72 1**X** M 2 □ F March 07, 1940 New York Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified Maryland Howard Columbia 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8610 Snowden River Parkway, #113 21045 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. 3 X Widowed 4 Divorced Completed White r than "natur the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "I any injury or other traumatic event, the Medonoe. College (1-4 or 5+) Elementary/Secondary (0-12) Mechanic Toyota Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Jack Greenberg Ada Pressman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Ida Court, Barrington, Rhode Island 02806 Scott Greenberg - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) United Hebrew Cem. 04/17/2012 | Arbutus, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. arnor 1232 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line amplicated Diverticularis from natural perforation Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury trans. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 spiral or Atlanding Physician: The law request that the Genth continue he 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary artery disease, Coronary artry bypass graft x? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed Cardiamyopathy, End Stage Renal disease, Diabetes Mullitus 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? Hyputension To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of within 24 hours after death.

To the Funeral Director; After ormuletely filled in by the funer 28d. Describe how injury occurred 1 Matural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier ompletely i 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D 00 65000 P25 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmore, MD 21229 Laton Ave. Williams arlin 31. Date filed (Month, Day, Year) State APR 23 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Ammended Box18 Per FH 4/26/12 WSH Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:45 O Bent HISCOCK 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ce Soi 5. Social Security Number I if Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 1 ∕ M 2 □ F 217-34-5823 7/22/1938 MD or 28a-f show aţ 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2XX No Baltimore Randallstown 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a Funeral USA 3812 Brownhill Rd. 21133 death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ₩idowed 4 Divorced Completed White Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Health Physicist Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ \_Mildred Shaffer Iinda Wheat Raymond R. Hiscock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Lori Jolbitado/Daughter 719 Temple Cliff Rd., Pikesville, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 4/16/2012 Winfield, MD 21. Signature of Funeral Service Licensee <sup>22</sup>Burrier-Queen Facility Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Ph sician/ disease or condition Due to (or as a consequence of): Canar Medical Examiner resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) signed by the atte in the past 12 months? Month Day Year Pregnant at time of death Linknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown chistory Lung page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes ျ Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pendina work after death. 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 029085 APRI Allena 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallstown MD egistrar's Signature 31. Date filed (Month, Day, Year) Barks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12:05 p M Sandra Clark Hall **April** 8 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death Examiner 4c. County of Death Carroll Hospice Dove House Carroll Westminster If Under 7. Age (In yrs, last birthday) Social Security Number If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months (Month, Day, Year) Hours 136-42-0123 Director 1 □ M 2**X** F Yrs 62 Sept 9, 1949 New Jersey Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No MD Carroll Westminster ö 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a o must be Funeral I 2835 Albert Rill Rd. 21157 USA items ; 12. Was Decedent Ever in U.S. Was Deceuc... Armed Forces? Ves 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or il edical Examine Black, White, etc. þ 1 Never Married 2 Married hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Specify: White Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) the Registered Nurse Nursina Be 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H if item 27 is marked of r other traumatic ever ပ Austin L. Clark Virginia Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Wilhelm Daughter 4376 Bark Hill Rd. Union Bridge, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 5 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Carroll Cremation Inc 4/11/2012 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facil Pritts Funeral Home & Chapel, PA wo 412 Washington Rd. Westminster, MD 23a. Part 1. Ent > the disease, or com — tions that caused shock, or leart failure. List only one cause on each line tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death detached 1 the 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a, Was an has prior to completion of cause of death? autonsy I or Attending Physician: The after death.

Director: After this certificate ! 2 🗆 No Yes 2 1 Tyes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending 1 ☐ Yes 2 ☐ No filled in by the Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Funeral Medical Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d Date signed (Mgnth, Day, Year) xson who completed cause of death (Item 23a) (Type, Print)

State

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ruth Elizabeth HART Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Hours (Month, Day, Year) Director 215-42-2978 1 □ M 2 🗶 F Yrs 69 Jan. 31 1943 Maryland 28a-f shov 10b. County must be notified at 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 X Yes 2 No Maryland Washington Hagerstown ь 10f. Zip Code 10g. Citizen of What Country? Funeral 23a E. Washington Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural" 3 X Widowed 4 Divorced Specify: Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Presser Laundry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Curtis Swandol Doris Jane Flint 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 2796 Britt Lane, Morristown, Roy Cheyenne Swandol Tn. 37814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/27/2012 Rose Hill Cemetery Hagerstown, Maryland Signature of Funeral Service Licensee Name and Address of Facility Minnich Funeral Home E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death enTricular disease or condition Medical resulting in death) **Examiner** 5 squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Exami as the burial-trai Due to (or as a consequence of) resulting in death) Last physiciar Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicis completely filled in by the funeral circlor, page 2 should be detached for use as the burn completely filled in by the funeral circlor, page 2 should be detached for use as the burn. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Be Completed 1 Tes 2 No 3 Probably 4 Unknown CIRRHUSIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed HYPERTENSION 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 2 WNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Prantitioner: To the best of my knowledge, death only one 29b. Signature and title of certifier

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TRANCISCO

DANIELS

29c. License number

MO061117

MeriTus Medical Center

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month <u>Sherry Deane Ross Henry</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death NICOMICS MEDICAL 512156414 PENINSUMA REGIONAL . Age (In yrs. last birthday) r If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months **Director** 218 40 6502 11/13/1944 1 □ M 2X□ F 67 MD Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 10d. Inside City Limits 1X Yes 2 ☐ No MD Berlin Worcester 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 10323 Henry Rd 21811 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No Completed by Black, White, etc. "natural", or 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give 3 ☐ Widowed 4 🛱 Divorced Specify: white Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) 12 permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N College (1-4 or 5+) waitress restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Franklin Ross Betty Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Ann Baker 1321 Middle Neck Dr. Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🔼 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 1st State Crematory 4/23/2012 Millsboro, DE A Service License 22. Name and Address of Facility The Burbage Funeral Home 108 William St.. Berlin, MD 21811 disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. Approximate shock, or heart ailure. List only one caus Interval Between Immediate Cause (Final Onset and Death Ph<sub>sician</sub> Can ces una Medical resulting in death) Due to (or as a consequence of): Examiner 7 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami duse (Disease of hijury as the burial-trai that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year 1 ☐ Yes 2 ☑ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be

To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur. P.O. Box 68760 Division of Vital Records,

Baltimore, Maryland 21215-0036

DH6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury, maryland 21801 100 East. Carroll Street 31. Date filed (Month

Wu,

State Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

070053

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

April 21, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Abrit 18, 2012 ay Joanna Holland 12:55 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Calvert County Nursing Center Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Hours April 2, 1920 (Country) Director 214-30-0115 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Calvert Sunderland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be Funeral "natural", or items 23a USA 137 Persimmon Hills Court 20689 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ filed within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify Completed 3 ₩idowed 4 Divorced Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Domestic Someone Else's Home other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever ည Alice Mackall General Chase Page 1 and 2 should I ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Department of Health ar Important: If item 27 is any injury or other trauonce. Frederick L. Holland - son 137 Persimmon Hills Court Sunderland, MD 20689 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Mt. Hope UM Church Cemetery | April 26, 2012 Sunderland, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Sewell Funeral Home, P.A. Bead 1451 Dares Beach Rd. Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on expline. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami executed burial-transit Cause (Disease or iinjury that initiated events Due to (or as a co resulting in death) Last physician s the burial Physician/Medical that the death certificate be Box 68760 as attending IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Yea 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ≥ Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed? death? 2 [ Yes Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) director Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After teted filled in by the funeral 5 Pending injury 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death or curred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day

Jan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PAUL DAVID HACKER APR 2012 8:57 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY BETHESDA WRNMMC If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUNE 20,1944 **Funeral** 6. Se: 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Months Country) MARYLAND Days 1 X M 2 - F 217-40-8710 **Director** 67 Yrs. Usual Residence of Decedent 28a-f show 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No DORCHESTER HURLOCK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6614 BRIARPATCH ROAD 21643 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married ģ 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Divorced WHITE Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) ag. 12 WARRANT OFFICER UNITED STATES NAVY Important: If item 27 is marked other any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 Is marked c 2 JOSEPH HACKER MAE FUNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) INGE EMMA HACKER, WIFE 6614 BRIARPATCH ROAD, HURLOCK, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 4 Donation 5 Other (Specify) VETERANS CEMETERY 4/23/2012 HURLOCK, MD Signature of Fund al Service Lice 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. LOWS, HELFENBEIN & NEWN SOUTH HARRISON STREET. 200 naticaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, . Enter the disease, or complications t shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ SIGMOID COLON PERFORATION disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner REFRACTORY ANEMIA MYELODYSPLASTIC SYNDROME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami death certificate be executed Cause (Disease or linjury and trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No Other 2 1 Tinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ieral Director: After filled in by the funera 1 X Natural work? 5 Pending 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760 P.O. Records, of Vital To the Hospital or Attending Division within 24 hours a completed

Baltimore, Maryland 21215-0036

TLS 9+VA

State Registrar

JEREMY G. PERKINS, 31. Date filed (Month, Day, Year

(Check

29b. Signatu

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) MD

29c. License number

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MD31266

8901 WISCONSIN AVENUE

WRNMMC, BETHESDA, MD 20889

32 Registrar's Signature APR 1 8 2012

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 04716/2012 3:46 P KATHLEEN MARIE JOHNSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery 13222 Midway Avenue Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 1 □ M 2**X** F Days Hours 09/04/1955 Director 579-62-9554 56 Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director be notified Rockville 1 Yes 2 X No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 23a o, Funeral USA 20851 13222 Midway Avenue Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in LLS 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify If Yes Give 3 Widowed 4 Divorced Specify: White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Food Retail Sales event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H

27 is marked of
traumatic ever ၉ Louise Dropps Earl Dahlquist 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13222 Midway Avenue, Rockville, MD 20851 June Katrina Williams/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ardent Crematory 4/25/2012 Hanover, MD 21. Signature Funeral Service License 22. Name and Address of Facility Snowden Funeral Home Lesig 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ 6 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence or, burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) ed by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Day Pregnant at time of death 1 ☐ Yes 2 🗷 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been sign page 2 should be 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 💢 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 🔊 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🗌 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5  $\square$  Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Gignature and title of co 29d. Date signed (Month, Day, Year, DMG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

| Martin   |                 | white are some some  | Pleas<br>amen                   | e Type or I<br>d item 1<br>State of                                 | Print in<br>per co<br>Marylar            | Black Ind / Dep   | <b>ndeli</b> l<br>artme  | ble Inl<br>16 vi                       | k. Ensure<br>t<br>Health and                        | All Copie<br>Mental Hy                | es Are                  | <b>e Legible</b><br>e                  | Э.              |                                |
|--|-----------------|--|---------------------------------|---|--|---|--------------------------|--|---|---------------------------------------|-------------------------|--|-----------------|--------------------------------|
| NMEND  | -D              | ENte COU   | RT OR                           | DER   |  |   |                          | te of L                                |   |                                       | Reg. N                  | 201                                    | 2               | 450                            |
| Physicia<br>Medic  | al              |  | Virgini                         | a Marine  | scu                                      | inia Ja<br>Iacob  |                          |  |   | 2. Date of D<br>Month<br><b>Apri1</b> | 1                       | 8, 201                                 | 2 3:            | ne of Death                    |
| Examine  |                 | 4a. Facility Name (if r. 8009 Exo  5. Social Security Nur  | dus Dri                         | ve  |  | In a file field and a state of the state of | Ga                       |  | Location of Deat<br>rsburg<br>If Under 24 Hrs       |                                       |                         | c. County of De                        | omery           |                                |
| Funeral<br>Director  |                 | 087-56-78<br>Usual Residence of  | 03                              | . Sex 7   | 6  | 9 Yrs.  | Month                    |  | Hours Min.  | 8. Date of B<br>(Month, D             | ay, Year)               |  | Romani          |                                |
| or 28a-f sh  |                 | Maryland  10e. Street and Number   | Montg                           | omery   | 100.01                                   | Gaithe  | rsbu                     | <b>rg</b><br>Zip Code                  |   |                                       | 100.0                   | Citizen of What (                      | 1 🗆             | de City Limits  Yes 2 X No     |
| h with the same same same same same same same sam  | neral           | 8009 Exod  | us Driv                         | re  |  |   |                          | 20882                                  |   |                                       | 1                       | nited S                                | -               |                                |
| , or amin  | ρ               | 11. Marital Status  1 Never Marrie  3 X Widowed 4  |                                 | 12. Was Decedor Armed Force 1 Yes 2 If Yes, Give Year or Date       | es?<br>X No                              |   |                          |  | ispanic Origin? (S<br>n, Mexican, Puert<br>Specify: | pecify Yes or No<br>o Rican, etc.)    | )-                      | 14. Race - An<br>Black, Wh<br>Specify: |                 | n,                             |
| in 72 hours<br>e.<br>nan "natur.<br>Medical E  | Completed       |  | 15. Decedent's ify only highest |   |  | 16a. Dece<br>(Give<br>life. L   | kind of w                | ual Occup<br>ork done o<br>se retired) | ation<br>during most of wor                         | rking                                 | 16b.                    | Kind of Busines                        |                 |                                |
| filed with<br>al Hygien<br><b>I other ti</b><br>vent, the  | Be              | 17. Father's Name (Fi  | irst, Middle, Las               | 5+  |  | Eng   | gine                     | er                                     | 18. Mother's Na                                     | me (First, Middle                     |                         | lear En                                | ginee           | ring                           |
| uld be<br>d Menta<br>marked<br>natic e   | 입               |  | omulus                          | Marine  | escu                                     |   |                          |  |   | Letit                                 |                         | Verza                                  |                 |                                |
| d 2 sho<br>alth and<br>27 is 1   |                 | 19a. Informant's Nan  Jeff Jac   |                                 | (Type, Print)   |  |   |                          |  | and Number or Ru<br>Ridge Ave                       |                                       |                         |  |                 | 378                            |
| Page 1 and<br>ment of Hea<br>ant: If item<br>ury or othe   |                 | 20a. Method of Dispo   | osition<br>Cremation 3          | Removal from S  | tate                                     | Place of Dispo<br>cemetery, creater   | osition (Na<br>matory or | ame of<br>other plac                   | :e)   | Date 23/2012                          | 20c. l                  | Location - City                        | or Town, Sta    | te                             |
| Departit.  Departit  Import  any inj  once.  | 1               | 21. Signature of Fund  | eral Service Lice               | ensee // O  | 0.                                       | 2   | 2. Name a                | and Addres                             | ss of Facility De                                   | Vol Fun                               | era1                    | Home                                   |                 |                                |
| Physician/   |                 | Immediate Cause (F disease or condition  | failure. List onli<br>inal      | omplications that car<br>y one cause on each                        | n line.                                  |   |                          |  | er Park<br>g, such as cardiac                       |                                       |                         | rsburg,                                | Approx          |                                |
| Medical<br>Examiner  |                 | resulting in death)  | ditions 1                       | Due to (or  | as a consec                              |   | with                     | n Reg                                  | ional Sp  | read                                  |                         |  | 42 D            |                                |
| executed ian and urial-transit   | Examiner        | Sequentially list con-<br>if any, leading to immasse. Enter Underly<br>Cause (Disease or in<br>that initiated events | nediate<br>ying<br>njury        | Due to (or  | as a consec                              | uence of):<br>rrowin  |                          |  | gional S  |                                       |                         |  |                 |                                |
| a a e  | =               | resulting in death) La   | 451                             | d. Diabet   |  |   | lled                     |  |   |                                       |                         |  |                 |                                |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director. | _               | IF FEMALE:<br>23b. Was decedent p<br>in the past 12 m<br>1 ☐ Yes 2 🛣<br>9 ☐ Unknown                                  | onths?                          |   | rth 2 🗌 Fet<br>int at time of            | tal death 3   | Ectopic Other (          | c pregnanc<br>specify)                 | ÷у  |                                       |                         | 23d. Date of o                         | lelivery<br>Day | Year                           |
| uires that the signed by the detail  | ۾               | Part II. Other signific  | cant conditions                 | s contributing to dea   | th but not re                            | sulting in the I  | underlying               | g cause giv                            | ven in Part I.                                      |                                       |                         | use contribute                         |                 |                                |
| The law req<br>ate has bee<br>page 2 sho   | Completed       |  |                                 |   |  |   |                          |  |   | per                                   | s an<br>opsy<br>formed? | prior to<br>death?                     | completion      | ngs available<br>n of cause of |
| sician:<br>certific<br>irector,  | Be              | 25. Was case referred examiner?  1  Yes 2 X  |                                 | Hospital:   |  |   |                          | Othe                                   | ace of Death (Che                                   |                                       |                         |  |                 |                                |
| nding Phys<br>tth.<br>: After this<br>e funeral d  | cate: To        | 27. Manner of Death  1 X Natural  2 \( \text{Decident} \)  | 5 Pending                       | 28a. Date of<br>(Month,   |  | ER/Outpatie<br>28b. Time o<br>injury  |                          | 28c. Injury<br>work                    | 4 □ Nursing F<br>/ at                               | dome 5 X Res<br>28d. Describe         | ·                       |  | ecify)          |                                |
| tal or Atterns after des al Director led in by the   | al Certificate: | 3 ☐ Suicide<br>4 ☐ Homicide  | 6 Could no<br>determine         | t be 28e. Place o   | f Injury - At h<br>, etc. <i>(Specif</i> | ome, farm, str  | eet, facto               | ory, office                            |   | 28f. Location<br>City or To           |                         | nd Number or Fi<br>e)                  | ural Route N    | lumber,                        |
| the Hospi<br>nin 24 hou<br>the Funer<br>npletely fil   | Medical         | (Check 2 Donly only only only only only only only  | Medical Exa                     | hysician: To the best<br>miner: On the basis<br>urse Pactitioner: 1 | of examination                           | on and/or inves   | stigation, i             | n my opinic                            | on, death occurred                                  | at the time, date                     | and plac                | e, and due to the                      | e cause(s) an   | d manner stated.               |
| P P P P P P P P P P P P P P P P P P P  |                 | 29b. Signature and ti  | tle of certifier                | 15  | lig.                                     | DIN   | > 25                     | c. License                             | number  | T                                     | 29d. Da                 | ate sjgned (Mor                        | th, Day, Yea    | 1/2                            |
|  |                 | 30. Name and addres  | higo, M                         | .D., 1854   | 0 Off                                    | lce Par   | k Dr                     |  | Montgome  | ery Vil                               | Lage                    | , MD. 2                                | 0886            |                                |
| State<br>Registra  | _               | 31. Date filed (Month,   | Day, Year) R 2 4 2              | 012 32/Reg  | istrar's Signa                           | d. 40   | Mad                      | ,                                      |   |                                       |                         |  |                 |                                |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4:50AM MARJORIE VIRGINIA JACKSON Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Doctor's Hospital Prince Georges Lanham 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours **Director** 1 M 2 X F 82 Washington, DO 12/29/1929 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No Prince Georges ΜD Greenbelt ь 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral death with 5904 Cherrywood Terrace #203 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Sackson, Maryoru Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 ₩ Widowed 4 □ Divorced Year or Dates Black other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than ' Elementary/Secondary (0-12) College (1-4 or 5+) Lepartment of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic every Administrative Assistant—GSA Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Minnie Ruth <u>Elijan Maree</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnita Mugg/daughter 2803 Nicholson St. Apt. 301, Hyattsville, MD 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Harmony Mem. Pk. 4/28/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service License 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St., Rockville, Md. 23a. Part 1. Enter the disease, or complications that caused the death o not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ bowe disease or condition resulting in death) Medical **Examiner** Cholangio Carcinomo Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) gal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) buri Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 - No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 -Natural 5 Pending injury after death. filled in by the 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical 29a. Certifier 🛂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and titl 000  $\Box J$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18 (9 DON eyeNe State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ senhans Month 4 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday, **Funeral** Hours **Director** 109-22-2395 1 X M 2 - F New York 6/18/1931 80 Usual Residence of Dece ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director 1 Yes 2 X No Maryland Anne Arundel Annapolis 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 802 Bermuda Court 21401 USA 12. Was Decedent Ever in U.S.
Arroed Forces?
1 ঐ Yes 2 ☐ No
If Yes, Give
Year or Dates. 1951-55 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 5 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. 'natural", Specify Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) years Sales Representative Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ Frederick George Josenhans Emma Marie Bremer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean A. Josenhans/ Wife 802 Bermuda Court, Annapolis, Maryland 21401 of Health item 27 20a. Method of Disposition
1 
Burial 2 
Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o Kalas Crematory 4/20/12 4 ☐ Donation 5 ☐ Other (Specify) Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home In ral S. vice Licenses once. 21. Signatur 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Ph\_sician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a cons cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as the burial-tran and Due to (or as a consequence of) the attending physician Physician/Medical certificate be P.O. Box 68760 IF FEMALE: nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death or within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter 호 in the past 12 months? Month Year Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of 84! ANNAPOLIS MOZIYOI State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

|                |  |              | State  | tate of Marylan   |                               | artment of F<br>tificate of D                   |  | , ,  | 201   | 2 11.512  |
|----------------|--|--------------|--|---|-------------------------------|---|--|--|---|---|
|                | - T.   |              | Registrar  1. Decedent's Name (First, Middle, Last)  |   | 001                           | imodic or E                                     | , can                                  | 2. Date of Deat                                |   | 3. Time of Death                                    |
|                | Physicia<br>Medic  |              | Shirley A. Jones   |   |                               |   |  | April  | 18 201                                      | 0708 ™  |
|                | Examir   | er           | 4a. Facility Name (if not institution, give street   |   |                               | 4b. City, Town, or                              |  | th   | 4c. County of De                            |   |
|                | Europal  |              | Anne Arundel Medi  5. Social Security Number 6. Sex  | .cal Cente  |                               | Anna  | polis                                  | 8. Date of Birth                               |   | Arundel   |
|                | Funeral<br>Director  |              | 217-52-3014  Usual Residence of Decedent   | 37.   | 2 Yrs.                        | Months Days                                     | Hours Min.                             | . (Month, Day,                                 | Year) C                                     | Sirthplace (State or Foreign<br>Country)<br>Aryland |
|                | rland<br>Shov<br>dat   | Į.           | 10a. State 10b. County   |   | y, Town or Loc                |   |  |  | ··  | 10d. Inside City Limits                             |
|                | Mary<br>28a-1<br>otifie  | Director     | Maryland Anne Arun   | idel G1   | en Bu                         | rnie  |  |  |   | 1 🗆 Yes 2 🛣 No                                      |
|                | ith the  | ral          | 10e. Street and Number   |   |                               | 10f. Zip Code                                   |  | 1  | 10g. Citizen of What 0                      | Country?  |
|                | ems a  | Funeral      | 1517 Tieman Dr.  | as Decedent Ever in U.S   | 3. 13. V                      | 210<br>Was Decedent of His                      |  | necify Yes or No-                              | USA<br>14. Race - Am                        | acrican Indian                                      |
| 21215-0036     | rs after de<br>ral", or it<br>Examine  | by           | 1 Never Married 2 Married 1  | rmed Forces?  Yes 2 No Yes, Give ear or Dates.  | If                            | Yes, specify Cubar                              | n, Mexican, Puer                       | to Rican, etc.)                                | Black, Wh                                   |   |
| 2-0            | 2 hour<br>"natu  | Completed    | 15. Decedent's Education (Specify only highest grade cor                                       | nn<br>mpleted)  | 16a. Deced                    | ent's Usual Occupa                              | ition                                  | rking  | 16b. Kind of Busines                        | s/Industry  |
| 121            | thin 7<br>ene.<br>than   | Som          | Elementary/Secondary (0-12) Co   | ollege (1-4 or 5+)  | Ìife. DC                      | NOT use retired)                                | 5                                      |  | Anne Aru                                    |   |
| d<br>2         | Hygie<br>Other<br>ent, ti  | Be (         | 12th 17. Father's Name (First, Middle, Last)   | 0   | C                             | ustodia:<br>                                    |  | me (First, Middle, M                           | Public S                                    | Schools   |
| Maryland       | l be fil<br>lental<br>rked<br>ric ev   | To           | Theodore Brown   |   |                               |   |  | M. Harr  | ,   |   |
| ary            | and Mand Is ma   |              | 19a. Informant's Name/Relationship (Type, Pri  | int)  | 19b. Mailin                   | g Address (Street a                             |  |  | City or Town, State, 2                      | Zip Code)   |
|                | nd 2 s<br>ealth<br>m 27  |              | Jolanda M. Wimbus  | h(Daughte   | r) 15                         | 17 Tiema  | an Dr.                                 |  |   |   |
| Baltimore,     | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |              | 20a. Method of Disposition  1 🛣 Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify) | 20b. P  | Bestery, crem                 | High (Name of<br>atory or other place<br>1 Park | 9)                                     | Date   | 20c. Location - City o                      | or Town, State                                      |
| Balt           | permit. Depart Import any inj  | 19           | 21. Signature of Funeral Service Licensee  |   | 1                             | mare Reese<br>922 Fore                          | est Dr.                                | s Mortu<br>Annapo                              | ary, P.A<br>lis, Md.                        | 21401   |
|                |  |              | 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause   | ns that caused the death<br>se on each line.  |                               |   |  |  |   | Approximate<br>Interval Between                     |
| ~.             | Physician  | 9            | Immediate Cause (Final disease or condition  | Phenina   | ia                            |   |  |  |   | Onset and Death                                     |
| 2              | Medical<br>Examiner  |              | resulting in death)  | Due to (or as a consequ   | ence of):                     |   |  |  |   |   |
|                | n ti   | Examiner     | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying             | Due to (or as a consequ   | ence of):                     |   |  |  |   |   |
|                | icate be executed<br>physician and<br>is the burial-transit  | Exan         | that initiated events c. — resulting in death) Last  | Due to (or as a consequ   | ence off:                     |   |  |  |   |   |
| 0              | be ex<br>sician<br>buria   | edical       | d d  |   | 3.133 3.7.                    |   |  |  |   |   |
| 3760           | ficate<br>g phy<br>as the  |              | a  |   |                               |   |  |  |   |   |
| go             | requires that the death certifichen signed by the attending should be detached for use a   | Physician/N  | in the past 12 months?   | yes, outcome of pregnar<br>☐ Live Birth 2 ☐ Fetal<br>☐ Pregnant at time of d<br>☐ Unknown | death 3 🗌                     | Ectopic pregnancy<br>Other (specify)            |  |  | 23d. Date of d                              | elivery<br>Day Year                                 |
| Р.<br>О.       | that the<br>ned by the<br>detach   |              | Part II. Other significant conditions contribut  | ing to death but not resu   | ulting in the un              | ideriving cause give                            | en in Part I.                          | 23e Did tob                                    | acco use contribute t                       | o the cause of death?                               |
|                | law requires the las been signers as 2 should be   | eted by      | Urinay Trac  | finted  | 131                           |   |  | 1 ☐ Ye   | _/ _  | Probably 4 Unknown                                  |
| Vital Records, | law<br>las   | Completed    |  |   |                               |   |  | 24a. Was an autopsy perform                    | y prior to<br>ned? death?                   | utopsy findings available completion of cause of    |
| <u>ta</u>      | sician;<br>certifi<br>rector   | m l          | 25. Was case referred to medical examiner?   | al:   |                               | 0.11  | ce of Death (Che                       | ck only one)                                   |   |   |
| <u>&gt;</u>    | Phys<br>r this<br>eral di  | 유            | TES 2 500  | 1 Dinpatient 2 1  | ER/Outpatient<br>28b. Time of | 3 DOA Other                                     | 4 ☐ Nursing F                          |  | nce 6 Other (Spe                            | cify)   |
| Division of    | To the Hospital or Attending Physician; The la within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page   | Certificate: | 1 Matural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be                          | (Month, Day, Year)  | injury                        | M 1 □ Y   | es 2 🗆 No                              | 28d. Describe how                              |   |   |
|                | pital or A<br>ours after<br>eral Direc<br>filled in b  |              | 4 El Homoide determined  | e. Place of Injury - At hor building, etc. (Specify)                                      |                               |   |  | City or Town,                                  | ,   |   |
|                | thin 24 hd<br>the Fun<br>the Fun   | Medical      | only one) 3 L Certifying Nurse Prac  | the basis of examination  | and/or investig               | gation, in my opinion<br>death occurred at the  | , death occurred<br>e time, date and p | at the time, date and<br>place, and due to the | I place, and due to the cause(s) and manner | cause(s) and manner stated. as stated.              |
|                | \ <u>\</u><br>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\   |              | 29b. Signature and title of certifier  |   | $\geq$                        |   | 158297                                 | 29   | Od. Date signed (Mont                       | th, Day, Year)                                      |
|                | ₹'3  |              | 30. Name and address of person who complete  Howked Journey  31. Date filed (Month, Day Year)  | 1D Annes  | Ayunde                        | el medica                                       | P Cent                                 | Anna   | pelis MD                                    | 21401   |
|                | Stat<br>Registra   | -            | 31. Date filed (Month, Day, Year)  APR 2 3 2012  | 32. Registrar's Signatu   | A. de                         | are   |  |  |   |   |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                            |  |               | For State of Maryland / Department of Health and Mental Hygiene  State Registrar Certificate of Death Reg. No. 2012 14514   |   |  |   |  |  |  |  |  |  |  |  |  |
|----------------------------|--|---------------|---|---|--|---|--|--|--|--|--|--|--|--|--|
|                            | Physicia   | in/           | Decedent's Name (First, Middle, Last)   | 2.1   | Date of Death                                      | 3. Time of Death                                  |  |  |  |  |  |  |  |  |  |
| 3.00                       | Medic<br>Examin  | cal           | JOYCE ARLYNE JAMES  4a. Facility Name (If not institution, give street and number)  | 4b. City, Town, or Location of Death  | APRIL 1  | 4, 2012 10:15 A M                                 |  |  |  |  |  |  |  |  |  |
|                            | LXGIIII  | ici           | 126 SUNSET BLVD.  | PRESTON   |  | CAROLINE  |  |  |  |  |  |  |  |  |  |
|                            | Funeral  |               | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)   |   | Date of Birth<br>(Month, Day, Yea                  | 9. Birthplace (State or Foreign                   |  |  |  |  |  |  |  |  |  |
|                            | Director   |               | 145-12-6164 1 ☐ M 2 <b>X</b> F 88 Yrs.  Usual Residence of Decedent   | JU  | ULY 21,  | NEW JERSEI  |  |  |  |  |  |  |  |  |  |
|                            | ryland<br>I-f sho<br>ied at  | Director      | 10a. State 10b. County 10c. City, Town or Li  |   |  | 10d. Inside City Limits                           |  |  |  |  |  |  |  |  |  |
|                            | he Ma<br>or 28a<br>e notif   | Dire          | MD CAROLINE PRESTO  | N 10f. Zip Code   | 10a  | 1   Yes 2 □ No  Citizen of What Country?          |  |  |  |  |  |  |  |  |  |
|                            | s 23a<br>nust b  | Funeral       | 126 SUNSET BLVD.  | 21655   |  | USA   |  |  |  |  |  |  |  |  |  |
|                            | 72 hours after death with the Maryland<br>n "natural", or items 23a or 28a-f show<br>fedical Examiner must be notified at  | y Fur         | 11. Marital Status  12. Was Decedent Ever in U.S.  13. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  | Was Decedent of Hispanic Origin? (Specify<br>If Yes, specify Cuban, Mexican, Puerto Ricar | Yes or No-<br>n, etc.)                             | 14. Race - American Indian,<br>Black, White, etc. |  |  |  |  |  |  |  |  |  |
| 036                        | ırs afte<br>ıral", o   | ed by         | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.  | 1 ☐ Yes 2X No Specify:  |  | Specify: WHITE                                    |  |  |  |  |  |  |  |  |  |
| 15-0                       | 72 hou<br>n "natu<br>ledica  | Completed     | (Give   | dent's Usual Occupation<br>kind of work done during most of working                       | 16   | b. Kind of Business/Industry                      |  |  |  |  |  |  |  |  |  |
| 21215-0036                 | e filed within 72 hour<br>ital Hygiene.<br>ed other than "natur<br>event, the Medical  |               | Elementary/Secondary (0-12) College (1-4 or 5+)   | OO NOT use retired)  I CER  | СО   | RRECTIONS INDUSTRY                                |  |  |  |  |  |  |  |  |  |
| and                        | e filed<br>ntal Hy<br>ed oth<br>event  | To Be         | 17. Father's Name (First, Middle, Last)   | 18. Mother's Name (Firs   |  | ,   |  |  |  |  |  |  |  |  |  |
| Maryland                   | ould be<br>nd Men<br>marke<br>imatic   |               | HARRY BERTRAM BECKINGHAM  19a. Informant's Name/Relationship (Type, Print)  19h. Mail   | ng Address (Street and Number or Rural Rou  |  |   |  |  |  |  |  |  |  |  |  |
|                            | 1 and 2 should be<br>f Health and Men<br>item 27 is marke<br>other traumatic   |               | T TUDA T CAROLL DALLOURD  | SUNSET BLVD., PREST   |  | 21655   |  |  |  |  |  |  |  |  |  |
| Baltimore,                 | a 0 4- 2-  |               | The Barrier E 12 Ordination of a Hornoval Hornoval  | matory or other place)  |  |   |  |  |  |  |  |  |  |  |  |
| altin                      | in part it   |               |   | KE CREMATION 4/16/2  2. Name and Address of Facility                                      | .012   S   | STEVENSVILLE, MD                                  |  |  |  |  |  |  |  |  |  |
| Ö                          | Depar<br>Impo<br>any ir  | 2 18          | JOHN & MERCERON   | FELLOWS, HELFENBEIN<br>200 SOUTH HARRISON ST  | & NEWNA  | M FUNERAL HOME, P.A.<br>EASTON, MD 21601          |  |  |  |  |  |  |  |  |  |
| I,                         |  |               | 23a. Part 1. Enter the disease, or complications that caused the death. Do not entended to shock, or heart failure. List only one cause on each line.  Immediate Cause (Final | piratory arrest,  | Approximate<br>Interval Between<br>Onset and De Jh |   |  |  |  |  |  |  |  |  |  |
|                            | Pnysician/<br>Medical  |               | disease or condition resulting in death)  Due to (or as a consequence of):  | ler distast   | . Carl   | Mark and be in                                    |  |  |  |  |  |  |  |  |  |
| A.                         | Examiner   | 7             | Sequentially list conditions, b. Ltherwicker  | 15eac 1/2015  |  |   |  |  |  |  |  |  |  |  |  |
|                            | red<br>Insit   | Examiner      | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Due to (or as a consequence of):         |   |  |   |  |  |  |  |  |  |  |  |  |
|                            | te be executed<br>nysician and<br>he burial-transit  | I Exa         | that initiated events c.  resulting in death) Last  Due to (or as a consequence of):  |   |  |   |  |  |  |  |  |  |  |  |  |
| 200                        | physic<br>the bu   | edical        | d   |   |  |   |  |  |  |  |  |  |  |  |  |
| Box 68760                  | eath certificate<br>attending phy  | m/m           | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy   | Teater-in agreement   |  | 23d. Date of delivery                             |  |  |  |  |  |  |  |  |  |
| Bô                         | e death<br>the atte  | Physician/Med | in the past 12 months?  1 ☐ Yes 2 ☐ No  9 ☐ Unknown  1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown   | Other (specify)   |  | Month Day Year                                    |  |  |  |  |  |  |  |  |  |
| P.O.                       | requires that the des<br>been signed by the s<br>should be detached  | by Ph         | Part II. Other significant conditions contributing to death but not resulting in the  | underlying cause given in Part I.   | 23e. Did tobaco                                    | co use contribute to the cause of death?          |  |  |  |  |  |  |  |  |  |
| ds,                        | equires<br>en sign<br>ould b   | ted k         | 5=12na disorder   |   | 1 🗆 Yes  | 2 No 3 ☐ Probably 4 ☐ Unknown                     |  |  |  |  |  |  |  |  |  |
| Division of Vital Records, | has be<br>ge 2 sh  | Completed     | 24a. Was an autopsy findings available prior to completion of cause of death?   |   |  |   |  |  |  |  |  |  |  |  |  |
| E<br>E                     | sician; The la<br>certificate ha<br>irector, page  | Be Co         | 25. Was case referred to predical   | 26. Place of Death (Check only  | 1 Yes 2 1  |   |  |  |  |  |  |  |  |  |  |
| ZĘ.                        | Physician; T<br>this certifica<br>ral director, p  | To B          | examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatie  | _ Other:  |  | e 6 ☐ Other (Specify)                             |  |  |  |  |  |  |  |  |  |
| n of                       | iding P<br>th.<br>After t<br>funera  | cate:         | 27. Manner of Death  1  Natural 5  Pending 2  Accident Investigation  28a. Date of injury (Month, Day, Year)  injury  | 28c. Injury at work?  M 28c. Injury at 28d. 6   | Describe how in                                    | njury occurred                                    |  |  |  |  |  |  |  |  |  |
| /isio                      | al or Attencs<br>after death<br>Director: \<br>d in by the   | Certificate:  | 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str   | eet, factory, office 28f. L   |  | t and Number or Rural Route Number,               |  |  |  |  |  |  |  |  |  |
| á                          | pital or<br>ours aft<br>eral Dii<br>filled ir  |               |   |   | City or Town, St                                   |   |  |  |  |  |  |  |  |  |  |
|                            | To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the | Medical       | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death check only one)  3 Certifying Nurse Practitioner: To the best of my knowledge     | tigation, in my opinion, death occurred at the ti   | time, date and pl                                  | ace, and due to the cause(s) and manner stated.   |  |  |  |  |  |  |  |  |  |
|                            | Vith<br>Com  |               | 29b. Signature and title of certifier   | 29c. License number   | 29d.   | Date signed (Month, Day, Year)                    |  |  |  |  |  |  |  |  |  |
|                            | 41   |               | 30. Name and address of person who completed cause of death (Item 23a) (Type, I   | D35750  | 0  | 4-16-2012   |  |  |  |  |  |  |  |  |  |
|                            | TES  |               | ROBERT B. SANCHEZ, MD 508 IDLEW   | LD AVENUE, SUITE 5,   | EASTON   | , MD 21601  |  |  |  |  |  |  |  |  |  |
|                            | Stat<br>Registra   | e<br>ir       | 31. Date filed (Month, Day, Year) 2012 33 Registrar's Signature   | Ke  |  |   |  |  |  |  |  |  |  |  |  |

DHMH 17 Rev 06-2011

| 12-03289 →<br>Brandon Will  | iam   |                |   | se Typ<br>St         | oe or<br>ate of          | <b>Print in</b><br>Maryla  | and / De                     | I <b>ndelil</b><br>epartme<br>Certifica | nt of       | Healt       | h and            | All Co<br>Menta                 | opies<br>al Hyg |                      |           | 201                           | 2             | 145                              |
|---|---|----------------|---|----------------------|--------------------------|----------------------------|------------------------------|---|-------------|-------------|------------------|---------------------------------|-----------------|----------------------|-----------|-------------------------------|---------------|----------------------------------|
| Phys  | ioio  |                | Registrar<br>1. Decedent's Name (                                       | First, Middl         | e.Last)                  |                            |                              | Jerunoa                                 | ie oi       | Dean        |                  |                                 |                 | . Date of Dea        |           |                               | 3. Time       | of Death                         |
| Medical Ex  |   |                | Brandon W   |                      |                          | overo                      |                              |   |             |             |                  |                                 |                 | Month<br>April 27, 2 | 2012      | Year                          | 213           | 5 hrs                            |
|   |   |                | 4a. Facility Name (if r   | ot institutio        | n, give st               |                            | ımber)                       |   | 4           |             |                  | ocation of                      | Death           |                      |           | County of Dea                 | ith           | _                                |
|   |   |                | 9665 Orland I   | Park Roa             | ad                       |                            |                              |   |             | Newb        |                  |                                 |                 | 0 D ( - ( D)         |           | harles                        | i-thologo (   | State of                         |
| Fune  |   |                | 5. Social Security Nur  |                      | 6. <b>Se</b> x           |                            | 7. Age (In y                 | rs. last birth                          | day)        |             | r 1 Year<br>Days | If Under<br>Hours               | 24Hrs.<br>Min.  |                      |           | Fore                          | eian          |                                  |
| Direc   | tor   | L              | 579-17-96   |                      | 1X M                     | 2F                         |                              | 24                                      | Yrs.        |             |                  |                                 |                 | 01/14                | 198       | 8                             | Journal J     | Lorida                           |
| 2   | ,   |                | Usual Residence of D<br>10a. State 10                                   | ecedent<br>b. County |                          | -                          | 10c.                         | City, Town                              | r Location  | on          |                  |                                 |                 |                      |           |                               | 10d. Ins      | side City Limits                 |
|   | 4   |                |   | •                    | 1 -                      |                            |                              | -11                                     | c           |             |                  |                                 |                 |                      |           |                               | 1 🔲           | Yes 2 ∑ No                       |
| ırylan  | j   | 용              | Maryland  10e. Street and Numb  | Chan<br>per          | ries                     |                            | IW                           | aldor                                   | L.          | 10f. Zip    | Code             |                                 |                 | 1                    | 0g. Citiz | en of What Co                 | untry?        |                                  |
| the Ma  | notified at once.   | Director       | 4703 Orle   | ans (                | Circl                    | Le                         |                              |   |             | 2           | 0601             |                                 |                 |                      | US.       | A                             |               |                                  |
| Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.                   | pe no   |                | 11. Marital Status  |                      |                          |                            | cedent Ever                  | in U.S.                                 |             |             |                  | oanic Origi<br>Mexican,         |                 | cify Yes or No       | )-        | 14. Race - Ame<br>White, etc. | erican India  | an, Black,                       |
| death   | nust  | Funeral        | 1 X Never Married   |                      | 1                        | Armed F                    | 2 🗌                          | No.                                     |             |             |                  |                                 | dento           | ilouri, oto.)        |           |                               |               |                                  |
| after   | iner  | ğ              | 3 Widowed   | _                    | 0                        | Yes, Give Yes<br>Dates:    |                              | <u> </u>                                |             | Yes 2       |                  | s <i>pecify:</i><br>on (Give ki | ad of us        | rk dono              |           | Specify: Whi                  |               |                                  |
| hours   | E   | 정              | 15. Decedent's Edu  |                      |                          | College (                  |                              |   |             |             |                  | DO NOT u                        |                 |                      | TOD. K    | and of Busines                | or in ladoury |                                  |
| 36<br>in 72   | die   | ple            | 12  | uary (0-12)          |                          | 2                          | 1401017                      | St                                      | uden        | t           |                  |                                 |                 |                      | Co        | 11ege                         |               |                                  |
| d with  | e Me  | Completed      | 17. Father's Name (F  | irst, Middle         | , Last)                  |                            |                              |   | <u>ader</u> |             | 1                | 8.Mother's                      | Name (          | First, Middle,       |           |                               |               |                                  |
| 21215-0036<br>buld be filed within 7<br>Mental Hygiene.   | ent, th   | Be             | Glenn De  | jesus                | Jove                     | ero                        |                              |   |             |             |                  |                                 |                 | Davis                |           |                               |               |                                  |
| 21<br>ould t  | tic ev  | 2              | 19a. Informant's Nam  |                      |                          |                            |                              |   |             |             | •                |                                 |                 |                      |           | ty or Town, Sta               | ite, Zip Coo  | de)                              |
| MD<br>id 2 sho<br>lith and  |   |                | Kimberly  |                      | s Jo                     | vero                       |                              | 47<br>20b. Place o                      |             |             |                  |                                 | _               | Ldorf,               |           | 20601<br>ocation - City       | or Town S     | tate                             |
| 5 1 an f Hea  | i i   |                | 20a, Method of Dispo  |                      | n 3                      | Removal fi                 | rom State                    | cremate                                 | ry or oth   | ner place)  |                  |                                 |                 |                      | -         |                               |               |                                  |
| Page:   | or oth  |                | 4 Donation 5  | Other S              | pecify:                  |                            | I                            | Brinsf                                  | ield        | l-Ech       | ols              | Crem                            | 5/1/            | 2012                 |           | arlotte                       |               |                                  |
| Baltimore,<br>permit. Pages 1 ar  | jury  |                | 21. Signature of Fund   | eral Service         | License                  | ) M                        | 00817                        |   | 22. N       | ame and     | Address          | of Facility                     | Bri             | nsfiel               | d-Ec      | hols Fu                       |               |                                  |
|   |   |                | 23a. Part I. Enter the  | diagona a            | Chy                      | ellas Tat                  | raused the                   | leath Do no                             |             |             |                  |                                 |                 |                      |           | otte Ha                       |               | ximate Interva                   |
| Physic<br>// /Medi  |   |                | failure. Ust only   | one cause            | on each                  | line.                      |                              |   |             |             |                  |                                 |                 | ,                    | ,         |                               | Between       | een Onset and<br>Death           |
| Exami   |   | -              | Immediate Cause (Fi   |                      |                          |                            | juries Co                    |   | וט עס ו     | owning      |                  |                                 |                 |                      |           |                               | +             |                                  |
|   |   | ı              |   |                      | b.                       |                            |                              |   |             |             |                  |                                 |                 |                      |           |                               |               |                                  |
|   |   | ē              | Sequentially list cond<br>if any, leading to imm<br>cause. Enter Underl | nediate              |                          | e to (or as                | a conseque                   | nce of):                                |             |             |                  |                                 |                 |                      |           |                               |               |                                  |
|   |   | Examine        | (Disease or injury the<br>events resulting in de                        | at initiated         | C                        | e to (or as                | a conseque                   | nce of):                                | _           |             | _                |                                 |                 |                      |           |                               |               |                                  |
| uted  | transit   |                | events resulting in de  | eatti) Last          | d.                       |                            |                              |   |             |             |                  |                                 |                 |                      |           |                               |               |                                  |
| execu   |   | Ca             | UNPENDED  |                      |                          | AMENDED                    |                              |   |             |             |                  |                                 |                 |                      |           |                               |               |                                  |
| Box 68760,  | After this certificate has been signed by the attentuing physician uneral director, page 2 should be detached for use as the burial - |                | IF FEMALE:  |                      |                          | 23c. If yes,               | outcome of                   | pregnancy                               |             |             |                  |                                 |                 |                      | 230       | d. Date of deliv              |               | V                                |
| <b>687</b><br>ertific   | e as th   | ian/           | 23b. Was decedent p<br>past 12 months?                                  |                      | ne                       | 1 Live                     | birth<br>nant at time        | of death                                | -           | tal death   | 3 [              | Ectopic                         | pregnar         | icy                  |           | Month                         | Day           | Year                             |
| eath o  | for us  | sic            | 1 Yes 2 No  | 9 🔲 Ur               | known                    | g Unkr                     |                              | ordeath g                               | Ot          | her (Spe    | city) _          |                                 |                 |                      |           |                               |               |                                  |
| C. He d   | ached   |                | Part II. Other signifi  | cant condi           | tions c                  | ontributing                | to death but                 | not resulting                           | in the L    | ınderlying  | cause g          | iven in Par                     | rt I.           |                      | _         | use contribute                |               |                                  |
| <b>P.O</b>  | igned<br>be det   | ğ              |   |                      |                          |                            |                              |   |             |             |                  |                                 |                 | 1 Ye                 | es 2 💟    | No 3 P                        | robably 4     | Unknown                          |
| d <b>s</b> ,  | plnou   | ete            |   |                      |                          |                            |                              |   |             |             |                  |                                 |                 | 24a. Was             |           |                               |               | ndings availab<br>on of cause of |
| of Vital Records,   | e nas<br>ge 2 sk  | Completed      |   |                      |                          |                            |                              |   |             |             |                  |                                 |                 |                      | ormed?    | death                         | ?             | 2 No                             |
| 8 = 1   | uricar<br>or, pag   |                | 25. Was case referre  | ed to medic          | al                       |                            |                              |   |             |             | 26.Place         | of Death (                      | Check o         |                      |           |                               |               |                                  |
| Zician  | iis cer<br>directo  | o Be           | examiner?   |                      | _                        | spital: 1                  | Inpatient                    | 2 ER/O                                  | utpatient   | 3 🗌 🛭       | AOC              | Other4                          | Nursing         | Home 5               | Reside    | ence 6 🗸 Ot                   | her: Scene    |                                  |
| of \  | Arter ur<br>funeral   | -              | 27. Manner of Death   |                      |                          | 28a. Date                  | e of Injury                  |   | Time of I   | njury       | 28c. Inju        | ry at Work                      | ?               | 28d. Describe        | how inju  | ury occurred rom bridge       | to water      | helow                            |
| on of the   |   | tio            | 1 Natural   |                      | nding                    | A 07                       | th, Day, Year)<br>D:<br>2012 | FOL<br>213                              |             |             | 1 \              | res 2                           | No              |                      |           |                               |               |                                  |
| Division<br>tal or Attendi  | ir by 1   | fica           | 2 Accident 3 Suicide  |                      | estigation<br>uld not be | 28e Pla                    | ce of Injury                 |   |             | et, factory | , office b       | ouilding, etc                   | - 1             | or Town.             | State)    | and Number or                 |               | e Number, Cit                    |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. | To the Fuoeral Director:<br>completely filled in by the   | Certification: | 4 Homicide  | det                  | ermined                  | (Specify                   | River                        |   |             |             |                  |                                 |                 | 665 Orland           | Park R    | load, Newbur                  |               |                                  |
| Hosp<br>24 ho   | etely f   |                | ( on our only   | Certifying F         | Physician                | : To the be                | est of my kno                | wiedge, de                              | ath occu    | rred at the | e time, da       | ate and pla                     | ce, and         | due to the car       | use(s) ar | nd manner as s                | tated.        | (s)                              |
| To the within 2   | omple   | Medical        | - (-  |                      | 8                        | on the basis<br>and manner | of examina<br>stated         | tion and/or i                           | nvestiga    |             |                  |                                 | curred at       | . me ame, dat        |           | Date signed (                 |               |                                  |
| -   |   | ž              | 29b. Signature and t  | itle of certif       | ier                      | //                         | 1                            | \                                       |             | 29          |                  | e number                        |                 |                      |           | il 28, 2012                   | wontn, Day    | , rear)                          |
| 5 M   | \   |                | (4)   | lin                  | Oro                      | ul.                        | MINC                         | ナ                                       |             |             | O.C.             | IVI. ⊏.                         |                 |                      | ^pr       |                               |               |                                  |
| 10  |   |                | 30. Name and addre  |                      |                          |                            |                              |   | 900 14      | / Balti-    | more S           | treet D.                        | altimo          | e MID 213            | 223       |                               |               |                                  |
|   |   |                | Melissa Bras  |                      |                          |                            | edical Ex                    |   | 900 V       | v. Daitir   | nore S           | ineet, B                        | aitiiiioi       | e, MD 212            |           |                               |               |                                  |
| R   | Si<br>egis  | tate<br>trar   | 31. Date filed (Month   | 2012                 | Ben                      | ا ساس                      | Registrar's S                | Park                                    |             |             |                  |                                 |                 |                      |           |                               |               |                                  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 22, 201°2 6:17 p M Sofiva Kozachenko Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5225 Pooks Hill Road Apt.1025S Bethesda Montgomery 8. Date of Birth
(Month, Day, Year)
Feb. 10,1911 cial Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days 1 M 2 X F Hours Ukraine Director 219-39-7340 101 Usual Residence of Decedent or 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No Md Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 5225 Pooks Hill Road Apt. 1025S 20814 Ukr<u>aine</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. регтіt. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ₺ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher School 1 any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Tvan Kozachenko Sofiva Kozachenko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5225 Pooks Hill Road Apt.1025S,Bethesda,Md.20814 Veronica Tishaev/Granddaughter Date 25, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cenetery crematory or other place)
Parklawn
Memorial Park 1 A Burial 2 Cremation 3 Removal from State April 4 Donation 5 Other (Specify) 2012 Rockville, Md Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home M00215 2222 Wisconsin Ave. N.W. Washington, D.C. 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Dementia ) Medical Due to (or as a consequence of) Examiner <u>Arteriosclerosis</u> Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ison in death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a P.O. Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 Yes 2 📉 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 2 No Accident Suicide Investigation Could not be the completed filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2. Registrar's Signature

Konstantin Khludenev,

APR 24 2012

31. Date filed (Month, Day, Year)

D59013

5530 Wisconsin Ave. #530, Chevy Chase, Md. 20815

April 23, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 2012 KOSTILIAH 215AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death 070 HUSPUTA rince 8. Date of Birth (Month, Day July 01 Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 X F 217-75-6935 Ghana **Director** 71 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director None Ghana Ассла 1 Tes 2 X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **23**a P.O. Box WJ242 New Weija Ghana None. ortant: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 X Never Married 2 Married Maryland 21215-0036 Yes 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify. Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 f Health and Mental Hygiene. Item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ (Unknown) John Aidoo Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emmanuel Ampong - Son 13019 Old Stage Coach Road, Laurel, Maryland 20708 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Ukn Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 K Removal from State 4 Donation 5 Other (Specify) Komenda, Ghana Komenda Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, ichel M(0) 24/11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HOWL Immediate Cause (Final Physician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) and and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 X No Month Day Year 1 Yes 2 2 9 Unknown After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hupertension 1  $\square$  Yes 2  $\undextbf{X}$  No 3  $\square$  Probably 4  $\square$  Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has performed? Yes 2 K No 1 🗌 Yes 2 🗌 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 💢 No Other: မ 1 🗌 Yes 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Medical Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. (Month, Day, Year) 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident completed filled in by the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) FG2554310 4/13/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Road, Laurel, Maryland 20707 Noah Gutierrez. M.D.,

DHMH 17 Rev 7/2009

State Registrar

Date filed (Month, Day, Year)

Box 68760

P.O.

Division of Vital

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

2 4 2012

Steven Wilks, M.D. 6001 Muncaster Mill Road, Derwood, MD 20855

32. Registrar's Signature

|                                 |  |                  | State Registrar   |  | Cer                               | tificate of L  | Death   | F   | Reg. No.               |  |   |               |
|---------------------------------|--|------------------|---|--|-----------------------------------|--|---|---|------------------------|--|---|---------------|
| J                               | Physicia<br>Medic  |                  | 1. Decedent's Name (First, Middle, Las<br>Young   | yol Kim  |                                   |  |   | 2. Date of Dea                                |                        | ) 1/2r   | 3. Time of Dea 1314                               | ath<br>M      |
|                                 | Examin   |                  | 4a. Facility Name (if not institution, give<br>Gilcrist Ce  |  |                                   | Colu   | Location of Death                                       |   |                        | y of Death<br>ward                                       |   |               |
|                                 | Funeral<br>Director  |                  |   | T. Age (In yrs. la   | st birthday)<br>Yrs.              | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                          | 8. Date of Birth 1 1 1 2 1 2 1 3              |                        |  | olace (State or Foi<br>brea                       | reign         |
|                                 | aryland<br>a-f show<br>ified at  | ector            | Usual Residence of Decedent 10a. State 10b. County MD Howard  | 10c. City  | , Town or Loc                     | ation<br>sville  |   |   |                        | 1  | 0d. Inside City Li                                |               |
|                                 | with the N<br>23a or 28<br>ast be not  | Funeral Director | 10e. Street and Number 6133 Rippling  | Waters Wall  | k                                 | 10f. Zip Code<br>2120  | 9   |   | 10g. Citizen of<br>US  |  | ntry?   |               |
| 980                             | ould be filed within 72 hours after death with the Maryland d Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at  |                  | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced   | 12. Was Decedent Ever in U.S<br>Armed Forces?<br>1  Yes 2  No<br>If Yes, Give<br>Year or Dates.          | 11                                | Vas Decedent of H<br>Yes, specify Cuba                                     | ispanic Origin? (Spo<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)              | Bla                    | ce - Americack, White,                                   | etc.  |               |
| Maryland 21215-0036             | ithin 72 hou<br>ene.<br>• than "nat<br>he Medica   | Completed by     | 15. Decedent's E<br>(Specify only highest gra<br>Elementary/Secondary (0-12)  |  | (Give I<br>life. D                | ent's Usual Occup<br>tind of work done on<br>O NOT use retired)<br>ectrici | during most of work                                     | ing   | 16b. Kind of L         |  | al Co.  |               |
| land 2                          | the filed when the filed when the fire event, the  | To Be            | 17. Father's Name (First, Middle, Last)  Kyung Wook Kin   | n  |                                   |  | 18. Mother's Nam<br>Kyung                               | ne (First, Middle, i<br>Kim                   | Maiden Suman           | ne)  |   |               |
| , Mary                          | 2 shouth and the and t |                  | 19a. Informant's Name/Relationship (7<br>Oliver Kim/Sor   |  | 19b. Mailir<br>613                | g Address (Street<br>3 Rippl   | and Number or Run<br>ing Wate                           | al Route Number<br>ers Wal                    | City or Town,<br>Lk Cl | State, Zip (   | ville,M   |               |
| Baltimore,                      | Page 1 and 3<br>ment of Healt<br>ant: If item 2<br>ury or other  |                  | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia  | Removal from State   | <sub>emetery, cren</sub><br>ate o | sition (Name of<br>natory or other place<br>f Heave                        | n 4/2   |   |                        | r Sp   | ring,Md   | i E           |
| Balt                            | permit, Page 1 a Department of H Important: If ite any injury or otl   |                  | 21. Signatur Funeral Service Licen  | undo   | 9                                 | HimaPadD<br>241 Col  | sR€NALD<br>umbia B                                      | I FUNEI<br>lvd.Si                             | RAL SE<br>lver S       | RVIC<br>prin   | E,P.A.<br>g,Md209                                 | <b>310</b>    |
| - 1                             | hysician/  |                  | 23a. Part 1. Enter the disease, or com<br>shock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)  | ne cause on each line.   | S                                 | er the mode of dyir  | ng, such as cardiac                                     | or respiratory arr                            | est,                   |  | Approximate Interval Betwee Onset and Deat        | th            |
|                                 | Medical<br>Examiner  | er               |   | b. Due to (or as a consequence)  |                                   | reumo  | nia   |   |                        |  | weeks   |               |
|                                 | recuted and  | Examiner         | Sequentially list conditions, if any leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Dysphae  pue tolor as a consequence   | sence of):                        |  |   |   |                        | -  | Month   | 5             |
| 09289                           | tificate be executed ng physician and as the burial transfer   | Medical          |   | o Dement   | ia                                |  |   |   |                        |  | Year.   |               |
| . Box 68                        | ne death certifica<br>r the attending pl<br>ched for use as t  | Physician/M      | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcome of pregnat 1 Live Birth 2 Fets 4 Pregnant at time of 0 9 Unknown                    | al death 3 🛚                      | Ectopic pregnan Other (specify)  | cy  |   |                        | ate of deliv   | ery<br>Day Year                                   | ,<br>         |
| ls, P.O                         | requires that the dea<br>been signed by the a<br>should be detached (  |                  | Part II. Other significant conditions of Sleep appear   | contributing to death but not res  | ulting in the u                   | inderlying cause g   | iven in Part I.   | 23e. Did to                                   | /                      | _  | he cause of death                                 |               |
| Division of Vital Records, P.O. | N 28   | Completed by     | Diabetes Mell   | itus   |                                   |  |   | 24a. Was<br>autop<br>perfo<br>1 \(\sum \) Yes | rmed?                  | . Were auto<br>prior to co<br>death?<br>1 \( \sum \) Yes | ppsy findings avail<br>ompletion of caus<br>2 🗔 🗷 | lable<br>e of |
| ital                            | ysician; The la<br>is certificate ha<br>director, page   | o Be             | 25. Was case referred to medical examiner?  1  Yes 2 No   | Hospital:<br>1 ☐ Inpatient 2 ☐   | FD/Outpatio                       | _ Oth  | Place of Death (Chec                                    | ome 5 Resid                                   | tanas e Voi            | than /Spacif   | Hospic  | 20            |
| on of \                         | nding Physath.<br>r: After this<br>ie funeral di   | icate: To        | 27. Manner of Death  Natural 5 Pending 2 Accident Investigation   | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury               | 28c. Inju<br>wor   | ry at   | 28d. Describe h                               |                        |  |   | <u> </u>      |
| Division                        | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral  | l Certificate:   | 3 Suicide 6 Could not I 4 Homicide determined   |  | ome, farm, str                    | eet, factory, office   |   | 28f. Location (S<br>City or Tow               |                        | ber or Rura  | l Route Number,                                   |               |
|                                 | To the Hospital within 24 hours of To the Funeral Completely filled  | Medical          | (Check 2 Medical Examonly one) 3 Certifying Nu  | rsician: To the best of my know<br>niner: On the basis of examinatio<br>rse Practitioner: To the best of | n and/or inves                    | tigation, in my opin   | ion, death occurred a                                   | at the time, date a                           | ind place, and o       | due to the ca  | ause(s) and manne                                 | r stated.     |
|                                 | To vith  |                  | 29b. Signature and title of certifier   |  |                                   | 29c. Licens  | se number   |   | 29d. Date sign         | ed (Month,   | Day, Year)  |               |
|                                 | , ,  |                  | 30. Name and address of person who  | 4  | n 23a) (Type,                     | Print)   |   | ^   | 4/24                   | 100  |   |               |
|                                 | Sta  | te.              | BINDU JOSEPH 31. Date filed (Month, Day, Year)  | 6336 CED/<br>32. Registrar's Signa   | AR L                              | ANE,   | COLUM   | BIA 1   | MD 2                   | 1044   |   |               |
|                                 | Registr  |                  | APR 2 4 2012  | 32. Registrar's Signa  | Aus                               | -  |   |   |                        |  |   |               |

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

|  |                             | For<br>State<br>Registrar   | 1100   |                   |   |                             |                 | d / Dep                                |                                      | nt of H                  | lealth                    |                   | All Copie<br>Mental Hy                       |                        | 2 (                    | )   2                 | 2 1452   | 21    |
|--|-----------------------------|---|--|-------------------|---|-----------------------------|-----------------|--|--------------------------------------|--------------------------|---------------------------|-------------------|--|------------------------|------------------------|-----------------------|--|-------|
| Physicia<br>Medio  | cal                         | 1. Decedent's Nam   | Bet  | t 4               | _   | au                          | 15              |  |                                      |                          |                           |                   | 2. Date of De Month                          | eath Da                | y <sub>4</sub> 2       | Year 0 [ 2_           | 3. Time of Death 4:25 ?                            | M     |
| Examin   | ier                         | 4a. Facility Name (ii  Carroll  |  |                   |   |                             |                 |  | 4b. City,                            |                          | Location<br>tmins         |                   |  | 4c                     | . County<br>Car        | of Death              | L  |       |
| Funeral<br>Director  |                             | 5. Social Security N<br>216-32-<br>Usual Residence  | 5272   | 6. Sex            | 1 2 🔀 F   |                             | n yrs. Ia<br>16 | st birthday)<br>Yrs.                   | If Unde<br>Months                    | r 1 Year<br>Days         | If Unde<br>Hours          | r 24 Hrs.<br>Min. | 8. Date of Bi<br>(Month, Da<br>7/21/         | ay, Year)              |                        | 9. Birth<br>Cour      | place (State or Foreig<br>htry)                    | חון   |
| yland<br>-f show<br>ed at  | ctor                        | 10a. State  | 10b. County                                      | 00                |   | 1                           | Oc. City        | , Town or Lo                           |                                      |                          |                           |                   |  |                        |                        |                       | 10d. Inside City Limits                            |       |
| the Mar<br>or 28a<br>e notifi  | Dire                        | MD<br>10e. Street and Nu  | Balti  | more              |   |                             |                 | Reis                                   | sters<br>10f. Zij                    | Code                     |                           |                   |  | 10g. Cit               | tizen of W             | /hat Cou              | 1 Yes 2 X  | 10    |
| th with<br>ns 23a<br>must b  | Funeral Director            | 1013 Co   | ckeys M  |                   |   |                             |                 |  |                                      | 1136                     |                           |                   |  | US                     | SA                     |                       |  |       |
| 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at   | þ                           | <ul><li>11. Marital Status</li><li>1 Never Man</li><li>3 Widowed</li></ul>                                      |  | ried              | Was Dece<br>Armed For<br>1 Tes<br>If Yes, Giv<br>Year or Da | rces?<br>2 <b>∳</b> No<br>e |                 |  | Was Deced<br>If Yes, spe             | cify Cuba                | n, Mexica                 | n, Puerto         | ecify Yes or No<br>Rican, etc.)              |                        |                        | k, White,             |  |       |
| hin 72 hou<br>ne.<br><b>than "natu</b><br>ie Medical   | Completed                   | Elementary/Sec  | 15. Deceder<br>ecify only highe<br>ondary (0-12) | st grade c        |   |                             |                 | life. D                                | kind of wo                           | rk done a                |                           | st of work        | ing  |                        | ind of Bu              |                       | ,  |       |
| lled wit<br>Hygie<br>other<br>ent, th  | Be                          | 17. Father's Name   | (First, Middle, L                                | .ast)             |   |                             |                 | secre                                  | cary                                 |                          | 18. Moth                  | ner's Nam         | e (First, Middle                             |                        |                        |                       | insurance  |       |
| uld be f<br>Menta<br>narked<br>natic ev  | 입                           | Clarenc   |  |                   |   |                             |                 |  |                                      |                          | Err                       | ıa Ca             | therine                                      | e Arr                  | dt                     |                       |  | _     |
| 12 shou<br>alth and<br>27 is n<br>r traum  |                             | 19a. Informant's Na William   |  |                   |   | nd                          |                 |  | _                                    |                          |                           |                   | al Route Number<br>Reist                     | -                      |                        |                       |  |       |
| permit. Page 1 and 2 st<br>Department of Health a<br>Important: If item 27 is<br>any injury or other tra   |                             | 20a. Method of Dis<br>1 Burial 2  |  | 3 🗆 Rem           |   | State                       | CE              | ace of Dispo<br>emetery, crer          | osition (Name                        | ne of<br>other plac      | e)                        |                   | Date /2012                                   | 20c. Lo                |                        | City or To            | own, State   |       |
| permit. Departr Importa any inji   |                             | 21. Signature of Fu   | ineral Service L                                 | icensee           | _   | 0074                        | 1               | - 1                                    | 2. Name ai                           |                          |                           |                   | line Fu<br>ampstea                           |                        |                        |                       |  |       |
| Physician/   |                             | Immediate Cause<br>disease or condition   | art failure. List c<br>(Final                    |                   | ions that o   | ch line.                    |                 |  | er the mod                           |                          |                           |                   |  |                        | <u> 10 21</u>          | 074                   | Approximate<br>Interval Between<br>Onset and Death |       |
| Medical<br>Examiner  |                             | resulting in death)   |  |                   | Due to (  | or as a co                  | onseque         | ence of):                              |                                      |                          |                           |                   |  |                        |                        |                       |  |       |
| be executed<br>sician and<br>burial-transit  | Examiner                    | Sequentially list co<br>if any, leading to in<br>cause. Enter Unde<br>Cause (Disease or<br>that initiated event | nmediate<br>erlying<br>injury<br>ts              | b                 | C   |                             | on              | ic L                                   | -ym                                  | pho                      | cyt                       | Li_               | Leui   | Ken                    | 114                    |                       |  |       |
| cate be exe<br>physician a<br>s the burial-  | cal                         | resulting in death)   | Last   | L <sub>d.</sub> _ | Due to (  | or as a co                  | onseque         | ence ot):                              |                                      |                          |                           |                   |  |                        |                        |                       |  |       |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi completely filled in by the funeral director, page 2.  | Completed by Physician/Medi | IF FEMALE:<br>23b. Was decedent<br>in the past 12<br>1 ☐ Yes 2 [<br>9 ☐ Unknown                                 | months?  |                   | If yes, out<br>1  Live I<br>4  Pregi<br>9  Unkn             | Birth 2 [<br>nant at tir    | Fetal           | death 3                                | ☐ Ectopic<br>☐ Other (s <sub>i</sub> |                          | У                         |                   |  |                        | 23d. Date<br>Mor       |                       | ery<br>Day Year                                    |       |
| uires that the signed by the s | ed by Pł                    | Part II. Other signit   | ficant condition                                 | ens contrib       | outing to de  | eath but                    | not resu        | ulting in the u                        | ınderlying                           | cause giv                | en in Parl                | : I.              |  |                        |                        |                       | ne cause of death?                                 | vn    |
| The law rec<br>ate has bee<br>page 2 sho   | Somplet                     |   |  |                   | _   |                             |                 |  |                                      |                          |                           |                   | 24a. Was<br>auto<br>perfe<br>1 \(\sum \) Yes | psy<br>ormed?          | p                      | rior to co<br>eath?   | psy findings available mpletion of cause of        |       |
| sician:<br>certific<br>irector,  | Be                          | 25. Was case referr examiner?   | red to medical                                   | Hosp              | oital:  | /                           |                 |  |                                      | Otho                     | ar.                       |                   | k only one)                                  |                        |                        |                       |  | _     |
| nding Phys<br>tth.<br>: After this<br>e funeral d  | cate: To                    | 27. Manner of Deat  1 Natural 2 Accident  |  | g                 | 28a. Date   |                             |                 | ER/Outpatier<br>28b. Time of<br>injury |                                      | 8c. Injury               | at                        |                   | ome 5 Resi<br>28d. Describe                  |                        |                        |                       | )  |       |
| tal or Atters after decarter al Director   | d Certificate:              | 3 ☐ Suicide<br>4 ☐ Homicide   | 6 Could determ                                   | not be            |   | of Injury<br>ng, etc. (S    |                 | ne, farm, str                          | eet, factor                          | , office                 |                           |                   | 28f. Location (<br>City or To                |                        |                        | r or Rura             | Route Number,                                      |       |
| the Hospi<br>thin 24 hou<br>the Funer<br>mpletely fill   | Medical                     | (Check 2 only one) 3  | Certifying                                       | xaminer: (        | On the bas  | is of exan                  | nination        | and/or inves                           | tigation, in<br>, death occ          | my opinio<br>urred at th | n, death c<br>ne time, da | ccurred at        | the time, date:                              | and place<br>the cause | , and due<br>(s) and m | to the ca<br>anner as | use(s) and manner sta<br>stated.                   | ited. |
| <b>5</b> ≥ <b>6</b> ⊗  |                             | 29b. Signature and  | weed f   | Leh               | /   | ND                          |                 |  | 1                                    | DOC                      | number                    | 172               | 9  | 29d. Dat               | te signed              | Month,                | Day, Year)   |       |
| DHZ  |                             | 30. Name and addr   |  |                   |   |                             |                 |  | Print)                               |                          |                           |                   | <i>(</i>                                     |                        |                        |                       |  |       |
| Stat   | e                           | Naveed 3 31. Date filed (Mont   | in, Day, Year)                                   |                   | 32. B   | egistrar's                  | Signatu         | ıre                                    |                                      |                          | 130                       | , We              | stminst                                      | er,                    | MD 2                   | 1157                  |  |       |
| Registra   | ar                          |   | APR 18   | 2012              |   |                             | ,               | A. 1                                   | ake                                  |                          |                           |                   |  |                        |                        |                       |  |       |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month O4 Year 2307 M Horace Dawson KEFAUVER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) Director 220-10-3324 1 XM 2 □ F 93 Nov.16 1918 Wash. D.C. Usual Residence of Decedent 28a-f show items 23a or 28a-f sho ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral 1118 Cottage Court 21740 USA 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Sandblasting Manager Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ٩ Lester M. Kefauver Ester V. Kirby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau 106 Hedgerow Lane, Chester, Pa. Joseph Kefauver - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 4/27/2012 Greencastle, Pa. 21. Signature of Funeral Service Lic 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ MYDCHRINAL ACUTE disease or condition 7, NU TES Medical resulting in death) Due to (or as a consequence of): Examiner ORONAMY fany, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): nding physician Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No for Day Month Year Pregnant at time of death should be detached P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, DIARTIES 1 Yes 2 No 3 Probably 4 Unknown MELLITUS Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy SUEGA ANNON performed certificate F.BRILLATION ANGIAL 2 No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred After 5 Pending work 24 hours after death. Funeral Director: Al 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 within 2 the only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 20c License number 29d. Date signed (Month, Day, Year)

State

31. Date filed (Mo

HAY, GR STOWN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 215 12 Gerald Dean Keadle 2012 Medical Apri 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Williamsport 247 East Potomac St. Washington Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Director 219-82-7033 Usual Residence of Dece 1 XM 2 | F 50 Nov.17,1961 Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Washington Williamsport o 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 247 East Potomac St. 21795 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. ıral", or iten Examiner r 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1X Never Married 2 Married Completed by should be filed within 72 hours after 1 Yes XX No Specify: 3 Widowed 4 Divorced Year or Dates White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Elmer Richard Keadle Dorothea Jean Gossard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Dana Beard - Sister Page 1 and 2 17 Oberlin Drive Falling Waters,West Virginia 25419 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of the Important: If ite any injury or other Cremation 3 L Hagerstown Crematory April 25,2012 Hagerstown, Maryland Osborned Lineral Home, P.A. Signature of Funeral Service 21795 #25 S. Conococheague St.Williamsport, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ 05 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Vear 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has autopsy death? performed 2 No Yes 2 N 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

TW-

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records,

11110

60

rnack

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>012</u> Physician/ Pokun Kim Month April 20 1:25 p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6401 Taylor Road Prince George's Riverdale 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Director 212-74-3519 1 X M 2 □ F May16, 1937 74 Korea Usual Residence of Decedent show filed within 72 hours after death with the Maryland al Hygiene.
d other then "neturel", or items 23a or 28e-f showert, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD P.G. 1 Yes 2 No Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6401 Taylor Road 20737 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 x Married ۾ Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2 M No Specify: Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic DC Government-WMATA Department of Health end Mental H Important: If item 27 is marked oth eny Injury or other trees 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jum Chul Kim Suk Boon Yoon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tae I. Kim/Wife 6401 Taylor Road, Riverdale, MD 20737 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date April 23 2012 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, VA 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensie Ler 500 University Blvd. W. Silver Spring, MD 20001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Pancreatic cancer disease or condition resulting in death) 2 months Medical Due to (or as a consequence of): <sup>'</sup>Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): igned by the attending physicien be deteched for use as the burit Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 ☐ Other (specify) Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires i within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be Records, 1 Yes 2 No 3 Probably 4 Winknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 2 🗌 No 1 Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ino 12 DOWS 8893 April 22 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21231 Hospital Browner, MA Johns Hen Kens

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year) APR 23 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amended #20 1 - State a, 20b, 20C, 4/13/2012, TLS Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 04 0 Bay 201<sup>Yea</sup> Earnett King 1:28 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caroline Nursing Home Denton Caroline 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days Hours Min. Country) 03-04-1919 259-14-9421 **Director** 93 Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 No Md. Caroline Preston 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 4821 Newton Road 21655 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No "natural", or þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced If Yes, Give Completed Specify: Year or Dates Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Janitor Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be file If Health and Mental I Item 27 is marked o ဂ္ဂ Lovett King Charity 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tessie Madden / Niece 2713 Chelsea Terrace, Baltimore, Md. 21216 20a. Method of Dispytition
1 ★ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of UN Commetter), crematory or other place)
Direct Crem., LLC 04/16/2012 20c. Location - City or Town, State Page 1 permit. Page 1
Department of I
Important: If it
any injury or o
once. Dover, DE 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bennie Smith Funeral Home 516 S.Main St., Hurlock, Md. 21643 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ advanced dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month 9 Unknown Division of Vital Records, P.O. Arter this certificate has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 1 ☐ Yes 2 ☑ No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Director. Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 29b. Signature and title of certifie 29c. License number 00053255 TUS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VA 3RS Breston 3683 Chaptenk 8-3 21655 31. Date filed (Month, Day, Year, 3. Registrar's Signature State APR 1 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 04/19/2012 George Melvin Law 1941 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery 4801 Mercury Drive Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign VA **Funeral** 8. Date of Birth 1**X** M 2 □ F Days 1072671931 **Director** 231-38-3437 80 28a-f show 10a. State 10c. City. Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 20853 4801 Mercury Drive within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc. "natural", or þ 1 Never Married 2 XMarried Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th Operational Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George W. Law Maddie Clark Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 4801 Mercury Drive, Rockville, MD 20853 Elsie Law/wife Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of F Important: If ite 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State injury o Cremation Sv : 05/01/2012 4 Donation 5 Other (Specify) Ardent Hanover, MD 22. Name and Address of Facility Snowden Funeral Home Signature Funeral Service Licensee 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir and that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 the attending p IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Day Pregnant at time of death Year signed by the a 9 Unknown a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No certificate I 1 Yes 2 No Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certificated filled in by the funeral director; p 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Yes မ Home 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) APR 24 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmed Heshmat, 7133 Millrun Drive, Derwood,

7002]

MD 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Madlyn Loveless April 7:15 p. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 212-54-3898 64 **Director** 1 🗆 M 2 🔀 F 3/13/1948 MD 28a-f show at 10a. State 10b Count 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified MD Carroll Finksburg 1 Yes 2 No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 2205 Old Westminster Pike, Apt. B 21048 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o. þ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. 1 ☐ Yes 2 ☐ No Specify: "natural" Completed 3 Widowed 4 Divorced Specify: white the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked ဂ္ John Henry Smith Martha Bryant 19a. Informant's Name/Relationship (Type, Print) husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21048 Clarence E. Loveless, Sr. item 27 2205 Old Westminster Pike, Apt. B, Finksburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Department of H Important: If ite any injury or ot 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State Carroll Cremation 4 Donation 5 Other (Specify) 4/13/2012 Hampstead, MD 21. Signature of Funeral Service Licensee M00741 22. Name and Address of Facility Eline Funeral Home 934 S. Main St., Hampstead, MD 21074 Denmer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical IF FEMALE use 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Dav Year Pregnant at time of death 1 ☐ Yes ∠ ₩ 9 ☐ Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner's 1 Yes 2 No Other: ြုင 1 Inpatient 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completely filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and Name and address of person who completed cause of death (Item 23a) (Type, Print) 14cm 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 25 epr me, g927,05/11/2012dhb Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 16.2012 DOROTHY MARIE LOVEJOY 9:35A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Min. (Month, Day, Year) **Director** 213-42-6406 1 🗆 M 2 💢 F 73 11/7/1938 Washington, DC "natural", or items 23a or 28a-f show edical Examiner must be notified at be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 🗆 Yes 2 ሺ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21409 USA 1239 Hampton Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) 12th College (1-4 or 5+) Secretary Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bernard Jones Dorothy Miller and i 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 1239 Hampton Road, Annapolis, Maryland 21409 Chalmers A. Lovejoy/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗔 Removal from State cemetery, crematory or other place, MD Veterans Cemetery | 4/24/12 Donation 5 Other (Specify) Cheltenham, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Phymician. disease or condition Medical resulting in death) OFFICIED OF MEDICAL EXAMINES Examiner Sequentially list conditions, if any lating sequence cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Bran use as the burial-transi the attending physician and resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be equition after death.

To the Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 2 No 1 Yes 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: မ 1X Yes Z ER/Outpatient 3 DOA 1 Inpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier 1. Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number ED 00069065 se of death (Item 23a) (Type, Print 30. Name and addr State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Genrikh Leptoukh Apri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) **Funeral** 6. Sex (Month, Day, Year) 09 / 23 / 1922 1 X M 2 □ F Months Days 237-77-3438 Director 89 ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 95 Dawson Avenue. #613 20850 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural". 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H ည Ephim Leptoukh (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health Maria Salganik - Daughter-in-Law 10915 Deborah Drive. Potomac. Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot 1 Durial 2 Cremation 3 Removal from State 04/20/2012 | Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gardens Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home lanewarmy 1232 11800 New Hampshire Ave., Silver Spring, MS 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician if for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month ed by the a 1 Yes 2 L 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Jas autopsy performed? 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Division 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature

2012

Montgomery

U.S.A.

White

Education

Onset and Death

9. Birthplace (State or Foreign Country) Republic

10d. Inside City Limits

1 Yes 2 X No

Georgia

6:00 am

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month 11:55 p M Shu Lee April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville 8. Date of Birth (Month, Day, Year) April 7, 1918 7. Age (In yrs. last birthday) **Funeral** Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days China 1 □ M 2 🖾 F Hours 541-46-5927 Director 94 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Montgomery 1 Yes 2 X No Derwood 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7100 Sonnett Court 20855 USA items death . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. and Mental Hygiene.

is marked other than "natural", or 1 Never Married 2 Married Completed by Yes 2 No Baltimore, Maryland 21215-0036 Specify: Asian 1 Yes 2 No Specify: If Yes, Give 3 Midowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Restaurant/Food Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within Service Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ George E. Lee Por Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Henry Y. C. Lee/Son 7100 Sonnett Court, Derwood, MD 20855 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 21 cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Washington Nat'l Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2012 Suitland, MD 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature 500 University Blvd. W., MD 20001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -₽nysician/ Hews Dira & aug disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease and Figure Examine Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death signed by the a d be detached f Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Yunknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page performe death? 1 Yes 2 No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital 2 XNo Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending within 24 hours after death.

To the Funeral Director: After Completed filled in by the funeral Director. 1 Natural 5 Pending injury 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) Rockville. 9901 med MUD State 3

Registrar

Box 68760 P.O. Division of Vital Records, in 24 hours after death.

the Funeral Director: After this certifical pletely filled in by the funeral director, Hospital or Attending 24 hours after death.

29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 3/0/8 completed cause of death (Item 23a) (Type, Print) 30. Name and address 10200 Coppermine Rl. Woodsboro, MD 21798 Gene 31. Date filed (Month, Day, Year) State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|   |                  | For State   | State of Marylan  | d / Depar                   | tment of I                         | Health and                            | Mental Hy                           | giene                                 | g                              |  |
|---|------------------|---|---|-----------------------------|------------------------------------|---------------------------------------|-------------------------------------|---------------------------------------|--------------------------------|--|
|   |                  | Registrar  1. Decedent's Name (First, Middle, Last)   |   | Certi                       | ificate of l                       | Death                                 |                                     | Reg. No. 2                            | 012                            | 1453   |
| Physic<br>Med   | ical             | Donald L. Morri   |   |                             |                                    |                                       | 2. Date of De Month                 |                                       | Year                           | 3. Time of Death                               |
| Exam  |                  | Long View Nursing   | Home  |                             |                                    | r Location of Dea<br>ester            |                                     |                                       | y of Death<br>arroll           |  |
| Funera<br>Directo   |                  | 213–30–8345 Usual Residence of Decedent   | 7. Age ( <i>lin yrs. la</i> s<br>M 2 □ F <b>81</b>  |                             | If Under 1 Year<br>Months Days     | If Under 24 Hrs<br>Hours Min          |                                     | y, Year)                              | 9. Birthpl<br>Countr           | ace (State or Foreigr<br>y)<br>MD              |
| Maryland<br>28a-f sho   | irector          | 10a. State 10b. County  MD Carroll  |   | Town or Locat               |                                    | · · · · · · · · · · · · · · · · · · · |                                     |                                       | 10                             | nd. Inside City Limits                         |
| th with the<br>ns 23a or<br>must be n   | Funeral Director | 10e. Street and Number  1811 Albert Rill F  | d.  |                             | 10f. Zip Code<br>21                | 1074                                  |                                     | 10g. Citizen of USA                   | What Countr                    |  |
| Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.     | Completed by Fu  |   | . Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates.                | 1 a. Decedent               | Yes 2X No                          | Specify:                              | pecify Yes or No-<br>o Rican, etc.) | Specify                               |                                | ite  |
| 2121<br>vithin 7<br>iene.<br>r than   | Som              | Elementary/Secondary (0-12)   | College (1-4 or 5+)   | (Give kind<br>life. DO N    | of work done di<br>OT use retired) | uring most of wor                     | king                                | 16b. Kind of B                        | usiness/Indu                   | stry   |
| nd filed w all Hyging dothe   | Be               | 17. Father's Name (First, Middle, Last)   |   | warehou                     | ise work                           |                                       | ne (First, Middle,                  | Acme Su                               |                                | rket   |
| aryla<br>should be<br>and Ment<br>is marker<br>tumatic e  | 욘                | Roland E. Morris  19a. Informant's Name/Relationship (Type,   | Print)  | 10h Mailin A                |                                    | Evelyn                                | M. Sheet                            | cs                                    |                                |  |
| Te, M<br>1 and 2 s<br>of Health<br>item 27<br>other tra   |                  | Erma M. Vane, sist  | er 20h Bla  | 3870 No                     | ormandy                            | Drive, A                              |                                     | , Hampst                              | ead, 1                         | MD 21074                                       |
| Baltimore, permit. Page 1 and Department of Hea Important: If item: any injury or other   |                  | 1 Burial 2 Cremation 3 Rer<br>4 Donation 5 Other (Specify)<br>21. Signature of fluneral Service Licensee  | noval from State Carr   | oll Cre                     | ry or other place<br>emation       | 4/19                                  | /2012                               | 20c. Location -                       | ead, M                         |  |
| Per De Co   |                  | Han C, Yu   | M01072  | 22. Na                      | me and Address                     | of Facility El                        | ine Fundampstead                    | eral Hom                              | ne<br>074                      |  |
| Physician/<br>Medical<br>Examiner   | ı,               | 23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, | ions that caused the death. If ause on each line.  Due to (or as a consequen                      | Oo not enter the            | e mode of dying,                   | such as cardiac                       | or respiratory arre                 | est,                                  | A                              | pproximate<br>terval Between<br>nset and Death |
| ath certificate be executed attending physician and for use as the burial-transit   | al Examiner      | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | Due to (or as a consequence   |                             |                                    |                                       |                                     |                                       |                                |  |
| cate by   | edical           | d   |   |                             |                                    |                                       |                                     |                                       |                                |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit. | hysician,        | in the past 12 months? 1  Yes 2 No 9 Unknown  | f yes, outcome of pregnancy   Live Birth 2   Fetal de   | eath 3 🗌 Ecto<br>th 5 🗌 Oth | er (specify)                       |                                       |                                     | 23d. Date                             | of delivery                    | / Year   |
| equires that<br>en signed<br>ould be de   | 2                | Part II. Other significant conditions contribu  | uting to death but not resulting  | g in the underly            | ying cause given                   | in Part I.                            | 1                                   | acco use contrib                      |                                | ause of death?                                 |
| The law recate has be page 2 sh   | Completed        |   |   |                             |                                    |                                       | 24a. Was an autopsy perform         | 24b. We pri                           | ere autopsy f                  | findings available etion of cause of           |
| sician<br>certifi<br>lirector   | и г              | 25. Was case referred to medical examiner?  1  Yes 2 No Hospii  | al:   |                             |                                    | of Death (Check                       | 1 L Yes 2<br>only one)              | No 1                                  | Yes 2                          | No   |
| ig Phy<br>ter this<br>neral d   | o   2            | 27. Manner of Death   | 1 Inpatient 2 ER/0  | Outpatient 3                | DOA Other:                         |                                       | ne 5 🗆 Residen                      |                                       |                                |  |
| Attending death. ector: Aff by the fur  | сеппсате:        | 1 → Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be   | (Month, Day, Year)  e. Place of Injury - At home,   | injury<br>M                 | work?                              | 2 🗆 No                                | 8d. Describe how                    |                                       |                                |  |
| ospital or<br>hours afte<br>ineral Dir  | ₹⊢               | 29a. Certifier 1 Certifying Physician:  | To the best of my knowled   | 1 0                         |                                    |                                       | 8f. Location (Stre<br>City or Town, | State)                                |                                |  |
| To the Howithin 24 To the Fuscomplete   |                  | (Check 2 Medical Examiner: Or only one) 3 Certifying Nurse Prace  | To the best of my knowledge<br>on the basis of examination and<br>etitioner: To the best of my kn | owledge, death              | occurred at the ti                 | me, date and plac                     | e, and due to the                   | place, and due to<br>cause(s) and man | the cause(s)<br>iner as stated |  |
| 3   |                  | 1   | 2   |                             | 29c. License nui                   | mber<br>3757ユ                         | 290                                 | I. Date signed (A                     | Month, Day, Y                  | 1  |
| State   |                  | 0. Name and address of person who corrolled TPF ZPCII ND 1. Date filed (Month, Day, Year)   | 5835  | 5.2                         | Ave                                | 14mes                                 | ıh-e                                | MD ?                                  | 21209                          |  |
| Registrar   |                  | APR 1 8 2012  | 32. Registrar's Signature   | par                         | 1                                  |                                       |                                     |                                       |                                |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April Thomas Pierre McCarthy 2012 14 3:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Greater Baltimore Medical Center Towson 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Maryland (Month, Day, Year)
May 5, 1939 214-38-7781 Days Hours Director 1 🔣 M 2 🗆 F 72 Usual Residence of Decedent 10c. City, Town or Location notified at 10d. Inside City Limits Director Baltimore Maryland Boring 28a-f 1 Yes 2 X No 10e, Street and Numbe ŏ 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 14827 Old Hanover Road 21020 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗶 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or ite 以*C*CAETHY TH9MAS Baltimore, Maryland 21215-0036 Black, White, etc. þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced Specify: Completed Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life\_DO NOT\_use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) welldriller welldrilling permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important; If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Ruth Disney ၉ Albert Lee McCarthy 19a. Informant's Name/Relationship (Type, Print) wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Elizabeth McCarthy 14827 Old Hanover Road Boring, Maryland 21020 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 19 1 X Burial 2 Cremation 3 Removal from State Evergreen Mem. Gans. Finksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Signature of Funeral Service License 22. Name and Address of Facility Eline Funeral Home 934 South Main Street Hampstead, Maryland 21074 M01072 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Peripheral Vasular disease Ph. sician/ Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

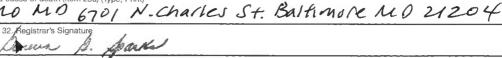
1 Yes 2 No Day Year Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death þ renal farlure Division of Vital Records, been sig Completed 1 Yes 2 No 3 Probably 4 Vunknown myocardial infarction 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 certificate 1 Yes 2 No Within 24 hours after use....
To the Funeral Director. After this certifics Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation M 1 Yes 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

ynthia soviano MO 31. Date filed (Month, Day, Year) APR 1 6 2012

· Cynthia Smans Ms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



00051347

29d. Date signed (Month, Day, Year)

4/14/2012

AMEND 24A, PER Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Minner The 1ma Frances 19 April 2012 3:30 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Envoy of Denton Denton Caroline 8. Date of Birth (Month, Day, Year) Jan 21 1917 5. Social Securify Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Months Days Hours Director 222-07-0068 Delaware Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a 423 S. 2nd Street 21629 USA Funeral 72 hours after death or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No Black. White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White ģ 3 XWidowed 4 ☐ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 in and Mental Hygiene. 7 Is marked other than "n: Elementary/Secondary (0-12) College (1-4or 5+) 11 Supervisor manufacturing line 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Day Simpson Sarah Ann Hickman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a Important: If item 27 Is any injury or other trau FDale Minner/ son 423 S. 2nd Street; Denton, MD 21629 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Apr 22 2012 Greensboro, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 21. Signature of Funeral Service Licenses Fleegle and Helfenbein Funeral Home, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** heimer disease or condition resulting in death) /Medical Due to (or as vonsequence of): Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine and resulting in death) Last Due to (or as a consequence of): Box 68760, physician certificate be Physician/Medical the attending use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death O 9□Unknown 9 Unknown signed by the detach σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed?

1 Yes X No certificate Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one | Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA ō 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of the Funeral Director: After in pletely filled in by the funeral Certification: 28d. Describe how injury occurred Division Hospital or Attending 24 hours after death. 1 Hatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Ecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 24 and manner stated To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0047534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 836 S 5th Street; Denton, MD 21629 Wafik Zaki, MD; 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 23 2012 Registrar DHMH 17 Rev 1/2001

NS 3

Ulysses Willard Mills

## ole.

| Please | ype or Print in Black Indelible Ink. Ensure All Copies Are Legi | b |
|--------|---|---|
|        | State of Manyland / Department of Health and Mental Hygiene     |   |

|  | 2 | 0 | - | 2 |  | 4 | 5 | 3 | L |
|--|---|---|---|---|--|---|---|---|---|
|--|---|---|---|---|--|---|---|---|---|

|                   |  |                | 1- For State<br>Registrar                                 |                            |                              | Ce               | rtificate       | e of De           | ath                      |               |              | R                            | leg. No.           | <u></u>                | 0 :                | 2 140   | 0  |
|-------------------|--|----------------|---|----------------------------|------------------------------|------------------|-----------------|-------------------|--------------------------|---------------|--------------|------------------------------|--------------------|------------------------|--------------------|---|----|
|                   | Physicia   |                | Decedent's Name (First)                                   |                            |                              |                  |                 |                   |                          |               | 2.           | Date of Dea<br>Month         | ath<br>Day         | Year                   | ,                  | 3. Time of Death                                  |    |
| ledica            | l Exami  | ner            | Ulysses Wi  |                            |                              |                  |                 | 1 6               |                          |               |              | April 16, 2                  |                    | 0                      | f D 11             | 0710 hrs  | _  |
|                   |  |                | 4a. Facility Name (if not in 6518 Eldorado R              | _                          | street and numb              | er)              |                 |                   | ty, Town, or<br>deralsbu |               | or Death     |                              |                    | . County o<br>Oorchest |                    |   |    |
|                   | uneral   |                | 5. Social Security Number                                 | 6. Sex                     | 7.                           | Age (In yrs.     | last birthda    |                   | Jnder 1 Yea              |               | er 24Hrs.    | 8. Date of Bir               |                    |                        |                    | hplace (State or                                  | _  |
|                   | irector  |                | 218–30–1177   |                            | M 2 F                        | 3 ( )            | 78              |                   | onths Day                | s Hours       |              | Feb. 1                       |                    |                        | Foreig             |   | ~e |
|                   |  |                | Usual Residence of Dece                                   |                            |                              |                  |                 |                   |                          |               |              |                              |                    |                        |                    |   |    |
|                   | y any  |                | 10a. State 10b. C   | •                          |                              | 10c. City        | , Town or L     |                   |                          | ,             |              |                              |                    |                        |                    | 10d. Inside City Limits                           |    |
| 3                 | aryland<br>Sa-f show<br>at once.   | ō              |   | orchest                    | er                           |                  |                 |                   | deral                    | sburg         |              |                              |                    |                        |                    | 1 Yes 2 X No                                      | ٥  |
|                   | Mary<br>28a<br>ed at   | Director       | 10e. Street and Number                                    |                            | -                            |                  |                 | 10f.              | Zip Code                 | 1632          |              | 1                            | -                  | zen of Wh              |                    | -   |    |
| 4                 | th the Maryland<br>23n or 28n-f sho<br>notified at once.   |                | 6518 Eldora   | do Road                    |                              |                  |                 |                   |                          |               |              |                              |                    | ted :                  |                    |   | _  |
| 4                 | ath wi   | Funeral        | 11. Marital Status 1 Never Married 2                      | Married                    | 12. Was Deced                | es?              | J.S. 13         |                   | ecify Cubar              |               |              | cify Yes or No<br>can, etc.) | 0-                 | 14. Race<br>White      |                    | can Indian, Black,                                |    |
| 1                 | ", or  |                | 3 Widowed 4   |                            | 1 X Yes<br>If Yes, Give Year | 2 No 52-15       | 5   1           | 1 Yes             | 2 X No                   | specify:      |              |                              |                    | Specify:               | Whit               | te  |    |
|                   | ntural   | d by           | 15. Decedent's Education                                  |                            | or Dates.                    |                  | 16a. Dec        | edent's Us        | ual Occupa               | tion (Give k  |              |                              |                    | Kind of Bus            |                    |   | _  |
| (O)               | /2 no  | Completed      | Elementary/Secondary                                      | 0-12)                      | College (1-4                 | or 5+)           |                 | _                 | working life<br>tal W    |               |              | 1)                           | E.                 | I. D                   | upor               | nt  |    |
| 003               | ene.   | Ĕ              | G.E.D.  |                            | _                            |                  | Sile            | et me             |                          |               |              |                              |                    |                        |                    |   | _  |
| 75                | Hyg<br>t d oth   |                | 17. Father's Name (First, I<br>Ulysses H.                 |                            |                              |                  |                 |                   |                          |               |              | irst, Middle, I              | Maiden             | Surname)               |                    |   |    |
| 212               | Menta<br>Mark<br>mark  | To Be          | 19a. Informant's Name/Re                                  |                            | pe, Print )                  |                  | 19b. M          | ailing Addr       | ess (Stree               |               |              | al Route Nur                 | mber, Ci           | ty or Towr             | ı, State,          | Zip Code)   |    |
| MD 21215-0036     | pernit. Pages I and a snounce be filed within 1.2 hours arter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. |                | Cora J. Mi  |                            |                              |                  |                 |                   |                          |               |              | derals                       |                    |                        |                    |   |    |
| <b>5</b>          | Healt<br>item  |                | 20a. Method of Disposition                                |                            | 7                            |                  | Place of Di     |                   | Name of ce               | - 1           |              | Date                         | 1                  |                        | -                  | Town, State                                       |    |
| Baltimore,        | rages<br>ent of<br>nt: Li  | Ш              | 1 X Burial 2 Cre 4 Donation 5 Ot                          | _                          | Removal from                 |                  |                 |                   | etery                    |               | 4/20         | /12                          | Elo                | dorad                  | 0, 1               | Maryland  |    |
|                   | partm<br>ports<br>ury o  |                | 21. Signature of Funeral S                                | ervice Licens              | ee .                         |                  |                 |                   | and Address              |               | ' Fran       | motom                        | Fune               | eral                   | Home               | e, P.A.   | _  |
| ď                 | ELGE   | ii d           | Mulhar  | 7. 2                       | skent                        |                  | (0)             | 216 N             | I. Mai                   | n St.         | ., Fe        | derals                       | burg               | g, MD                  | 21                 | 632   |    |
|                   | ysician<br>I di al   |                | 23a. Part I. Enter the disea<br>failure, List only one    |                            |                              | ed the death     | n. Do not er    | nter the mo       | de of dying,             | such as ca    | ardiac or re | espiratory arr               | rest, sho          | ock, or hea            | rt                 | Approximate Interval<br>Between Onset and         |    |
|                   | aminer   | 9              | Immediate Cause (Final dor condition resulting in de      |                            | ontact Guns                  |                  |                 | ad                |                          |               |              |                              |                    |                        |                    | Death   |    |
|                   |  |                |   | h                          | ue to (or as a co            | nsequence o      | <b>ਾ</b> ):     |                   |                          |               |              |                              |                    |                        |                    |   |    |
|                   |  | Je.            | Sequentially list condition<br>if any, leading to immedia | e D                        | ue to (or as a co            | nsequence (      | of):            |                   |                          |               |              |                              |                    |                        |                    |   | _  |
|                   | _  | Examiner       | (Disease or injury that init                              | ated <sup>c.</sup> _       | ue to (or as a co            | nsequence o      | of).            |                   |                          |               |              |                              |                    |                        |                    | <u> </u>  | _  |
| 7                 | and - transit  |                | events resulting in death)                                | d.                         | 20 to (0. 20 2 0             |                  | ,-              |                   |                          |               |              |                              |                    |                        |                    |   |    |
|                   | physician and<br>the burial - transi   | /Medical       | UNPENDED  |                            | AMENDED                      |                  |                 |                   |                          |               |              |                              |                    |                        |                    |   |    |
| 760,              | physician  | Mec            | IF FEMALE:  |                            | 23c. If yes, out             |                  | gnancy          |                   |                          |               |              |                              | 230                | d. Date of             | delivery           |   | -  |
| 89                |  |                | 23b. Was decedent pregna past 12 months?                  | nt in the                  | 1 Live birth                 | at time of de    | 2 _<br>eath 5 _ | Fetal de          |                          | Ectopic       | pregnanc     | у                            |                    | Month                  | C                  | ay Year   |    |
| Вох               | the attending<br>red for use as  | Physician      | 1 Yes 2 No 9  | Unknown                    | 9 Unknowr                    |                  | 2               | Other (           | specity) _               |               |              |                              |                    |                        |                    |   |    |
| 0.                | d by th  |                | Part II. Other significant                                | onditions                  | contributing to de           | eath but not i   | resulting in    | the underly       | /ing cause o             | iven in Pa    | rt I.        |                              |                    | _                      |                    | the cause of death?                               |    |
| Р.О               | ane taw requires mat me<br>cate has been signed by the<br>page 2 should be detached  | d by           |   |                            |                              |                  |                 |                   |                          |               |              | 1 Yes                        | s 2 🗸              | No 3                   | Prob               | abiy 4 Unknown                                    |    |
| rds               | s peen should  | lete           |   |                            |                              |                  |                 |                   |                          |               |              | 24a. Was<br>autor            |                    |                        |                    | topsy findings available<br>ompletion of cause of | е  |
| of Vital Records, | rne lav<br>cate has  | ompleted       |   |                            |                              |                  |                 |                   |                          |               |              | perfo                        | rmed?              |                        | eath?<br>✓ Ye      | s 2 No  |    |
| E .               | certificate<br>ector, page   | BeC            | 25. Was case referred to r                                |                            |                              |                  |                 | -                 | 26.Place                 | of Death (    | (Check onl   | y one)                       |                    |                        |                    |   | _  |
| Z S               | his  | 임              | examiner?<br>1 <b>✓</b> Yes 2 N                           | o Ho                       | espital: 1 Inpe              | atient 2         | ER/Outpa        | itient 3          | DOA                      | Other4        | , ,          |                              |                    | nce 6                  |                    | : Scene   |    |
|                   | After t  |                | 27. Manner of Death  1 Natural 5                          | Taxan o                    | 28a. Date of<br>FOUND:       | njury<br>y,Year) | 28b. Time       | e of Injury<br>)· | -                        | ry at Work?   | 121          | 3d. Describe<br>ubject sho   |                    | iry occurre            | ed                 |   |    |
| sior              | r death<br>ector:<br>by the  | catic          | 2 Accident  | Pending<br>Investigation   | Apr 16, 20                   | 12               | 0610 hr         | s                 |                          | Yes 2 ✓       |              |                              | 044                | - 4 51                 | D                  |   | _  |
| Division          | ours after<br>ours after<br>neral Dire<br>filled in b  | Certification: | 3 Suicide 6   | Could not be<br>determined | 28e. Place o                 |                  |                 | street, tac       | ory, onice c             | oullaing, etc | c. 20        | or Town, \$<br>18 Eldorad    | Street a<br>State) | na numbe<br>1 Federa   | r or Kui<br>Isbura | ral Route Number, City                            | ,  |
|                   | hours<br>uners   | ပ္             | 4 Homicide 29a. Certifier                                 |                            | n: To the best o             |                  |                 | occurred at       | the time da              | ate and nia   |              |                              |                    |                        |                    |   | -  |
| 4                 | within 24 hours after To the Funeral Dire completely filled in b   | edical         | (Critical orlin)  | al Examiner:               | On the basis of e            | xamination       |                 |                   |                          |               |              |                              |                    |                        |                    |   |    |
| , F               | To t   | Me             | 29b Signature and title of                                |                            | and manner state             |                  |                 | T                 | 29c. Licens              | e number      |              |                              | 29d. l             | Date signe             | d (Mor             | nth, Day, Year)                                   | _  |
|                   |  |                | 6/11  | 11                         | 11                           | 1                | -               |                   | O.C.                     | M.E.          |              |                              | Apri               | il 17, 20              | 12                 |   |    |
|                   |  |                | 30. Name and address of                                   |                            |                              |                  |                 |                   |                          |               |              |                              |                    |                        |                    |   | _  |
|                   |  |                | Zabiullah Ali, M.E  |                            | tant Medical                 |                  |                 | V. Baltin         | nore Stre                | et, Baltir    | more, M      | ID 21223                     | _                  |                        |                    |   | _  |
|                   | St<br>Regist   |                | 31. Date filed (Month, Day                                | Year)<br>2012              | 32. Regis                    | trar's Signat    | ure             | 4                 |                          |               |              |                              |                    |                        |                    |   |    |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>012</u> Physician/ 11:40 PM Charles McKee Apri1 14 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 1062 Double Gate Road Davidsonville Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 6. Sex 1 X M 2 □ F Months Days Hours Min. 11/6/1925 New Jersey **Director** 146-18-8268 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic area. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 X No Maryland Anne Arundel Davidsonville 10e. Street and Number 10g, Citizen of What Country? 21035 USA 1062 Double Gate Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No 3 ☐ Widowed 4 ☐ Divorced White Completed Year or Dates. W. W. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 5+ years Professional Civil Engineer Dewatering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Ernest McKee Elsie Dickson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Gloria McKee/ Wife 1062 Double Gate Rd., Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 4/21/12 Edgewater, Maryland 21. Signature of Furneral Service Lice 22. Name and Address of Facility George P. Kalas Funeral Home Island Rd. Edgewater. MD 21037 Solomons 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each line ediate Cause (Final Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ por Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniun that initiated events resulting in death) Last as the burial-tran Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time - 1 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No ned by the a cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatura and title of certifie

State Registrar

ew

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #26, PER VERBAL G930 8/24/12 TRT of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ Charles A. Merson 16 2012 4:50 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) Hours Months Director 215-30-2757 1**∑** M 2 □ F 79 Nov. 28, 1932 Marvland show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f shoi ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21409 USA 1136 Little Magothy View Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?
1 

Yes 2 □ No Black, White, etc. Completed by 1 Never Married 2 X Married X Yes Baltimore, Maryland 21215-0036 1953 1955 1 Yes 2 No Specify: Specify: White 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Westinghouse Logistics Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mollie Katolic Ernest Merson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1136 Little Magothy View Annapolis, MD 21409 Department of Health Important: If item 27 any injury or other trong once. Evelyn M. Merson/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Barranco & Sons, P.A. Seve
495 Ritchie Hwy. Severna Severna Park Funeral Home erna Park, MD 21146 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Phymician/ disease or condition 200000 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical the use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death be detached Yes 2 No 9 Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 U 24a. Was an autopsy Yes Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 Yes 2 No မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural work? injury 5 Pending Division To the Hospital or Attendin
within 24 hours after death.
To the Funeral Director: Af
completely filled in by the fu Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number H007048 Name and address of person who completed cause of death (Item 23a) (Type, Print) G+1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month April Thomas Francis McBride 16 4:11 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth  $J_{uly}^{(Month, Day)}$ 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 ₹ M 2 □ F <sup>Year)</sup>1942 Massachusetts **Director** 033-30-3865 69 ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Marvland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 421 Hamlet Club Dr. 21037 #101 12. Was Decedent Ever in U.S. Argued Forces?
1 ⚠ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify White 1 ☐ Yes 2 🕅 No Specify: Completed 3 Divorced Year or Dates. 1960 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) General Operations Manager Flooring Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John E. McBride Julia E. Fitzsimmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith A. McBride/ Wife 421 Hamlet Club Dr. #101, Edgewater, MD 21037 20a. Method of Disposition
1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Lakemont Meml. Gdns. 4/19/2012 |Davidsonville, MD of uneral S Licensee 22. Name and Address of Facility George P. Kalas Funeral Home do 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physici\_n 21507515 AR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any seeing to increase cause. Enter Underlying Duin to (or as a nonsequence of): Exami Cause (Disease or linjury that initiated events signed by the attending physician and be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the buri Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Dav Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 I ER/Outpatient 3 TOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛣 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature of person who completed cause of death (Item 23a) (Type, Print) 2+1 01) DEFONSE

State Registrar

|  |                 | 1 - For State State Registrar  |   | rtificate of E  |                      | ,                   | Reg. No.  |                         |   |  |
|--|-----------------|--|---|---|----------------------|---------------------|---|-------------------------|---|--|
| Physic   | ian/            | 1. Decedent's Name (First, Middle, Last)   | -   |   |                      | 2. Date of Dea      | ath   | Year                    | 3. Time of Death                          |  |
| Med  | dical           | Parbaca Moore  4a. Facility Name (if not institution, give street and number                                   | e1  |   |                      | 04                  | 19 201  | 2                       | Q809 W                                    |  |
| Exam   | ııner           | Anne Arundel Medical Cen   | ,   | Annap   | Location of Death    |                     | 4c. County  | of Death  Aruno         | 1 <sub>0</sub> 1                          |  |
| Funera   | al              | 5. Social Security Number 6. Sex 7.  | Age (In yrs. last birthday)                   | If Under 1 Year Months Days                                 |                      | 8. Date of Birtl    | h   | 9. Birthpla             | ace (State or Foreign                     |  |
| Directo  | or              | Usual Residence of Decedent  | 90 Yrs.                                       | IVIOIILIIS  | riodis Iviiii.       | 10/07/              |   | PA.                     | .,  |  |
| and<br>show<br>Lat   | 5               | 10a. State 10b. County   | 10c. City, Town or Lo                         | ocation   |                      |                     |   | 10d. Inside City Limits |   |  |
| Maryla<br>28a-f  | Director        | MD Anne Arundel  | Annapol:                                      | is  |                      |                     |   |                         | 1X Yes 2 □ No                             |  |
| h the<br>Sa or S   | al Di           | 10e. Street and Number   | -   | 10f. Zip Code   | 0.1                  |                     | 10g. Citizen of V   | Vhat Countr             | y?  |  |
| ith wit<br>ms 23<br>must   | Funeral         | 800 Bestgate Road  |   | 214   |                      |                     | USA   | ٠.                      |   |  |
| ire, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at  | ā               | 11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 X Yes 2  1 Yes, Give Year or Dates | □ NowII                                       | Was Decedent of Hi<br>If Yes, specify Cuba<br>1 ☐ Yes 2🏋 No |                      | Rican, etc.)        | 14. Race - American Indian,<br>Black, White, etc.<br>Specify: White |                         |   |  |
| 15-C   | plet            | 15. Decedent's Education (Specify only highest grade completed)  | (Give   | dent's Usual Occup<br>kind of work done o                   |                      | 16b. Kind of Bu     | ısiness/Indu  | ustry                   |   |  |
| ithin 7 ene.   | Completed       | Elementary/Secondary (0-12) College (1-4-12) 02  | or 5+)  | ONOT use retired) emaker                                    |                      |                     | 0   | Uomo                    |   |  |
| iled w<br>I Hygi<br>other  | Be              | 17. Father's Name (First, Middle, Last)  | TIOME   | Illakei   | 18. Mother's Nam     | e (First, Middle,   |   | <u>Home</u>             |   |  |
| Vlar id be f Menta arked   | 은               | Stephen L. Balencic  |   |   | Anna Ro              | se Yar              | novich  |                         |   |  |
| Marylanc<br>Should be file<br>h and Mental H<br>7 is marked of<br>traumatic ever   |                 | 19a. Informant's Name/Relationship (Type, Print) Dau   | ghter 19b. Maili                              | ng Address (Street a  | and Number or Run    | al Route Number     | ; City or Town, S   | tate, Zip Co            | ode)                                      |  |
| or Health of Hea |                 | Patricia Moore Stefanelli 20a. Method of Disposition   | 705 ]<br>20b. Place of Dispo                  | Wilson  |                      |                     |   | O:: -                   |   |  |
| Page 1   |                 | 1   Burial 2 □ Cremation 3 □ Removal from St 4 □ Donation 5 □ Other (Specify)                                  | ate cemetery, crei                            | matory or other plac  | ce)                  | Date                | 20c. Location -   | •                       |   |  |
| Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", of any injury or other traumatic event, the Medical Examany injury or other traumatic event, the Medical Exam   | i ouce          | 21. Signature of Supering Service Licensee   | Hillcrest                                     | 2. Name and Addrest<br>Hardesty                             | F 10A -              |                     | Annapol   |                         |   |  |
|  |                 | 23a. Part 1. Enter the disease, or complications that cau  | sed the death. Do not ent                     | -   |                      |                     |   |                         | Approximate                               |  |
| Physician  | 7               | shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition               | LLENTIA                                       |   |                      |                     |   |                         | Interval Between<br>Onset and Death       |  |
| Medica<br>Examine  | al              | regulting in death)  | as a consequence of):                         |   |                      |                     |   | _                       | 2415                                      |  |
| LXaIIIII   |                 | Sequentially list conditions, b.   |   |   |                      |                     |   |                         |   |  |
| ed   | Examiner        | Sequentially list conditions, if any leading to inneolate cause. Enter Underlying Cause (Disease or injury     | as a nunsequence of:                          |   |                      |                     |   |                         |   |  |
| xecut<br>n and<br>ial-tra  |                 | that initiated events C.   | as a consequence of):                         |   |                      |                     |   | _                       |   |  |
| 8760 ificate be executed g physician and as the burial-transit   | Medical         | d  |   |   |                      |                     |   |                         |   |  |
| <b>~</b> ≠ 50 €  |                 | IF FEMALE:   |   |   |                      |                     | 7   |                         |   |  |
| ords, P.O. Box 68 requires that the death certiles been signed by the attendin should be detached for use  | Physician/      | 23b. Was decedent pregnant in the past 12 months?  | th 2 🗌 Fetal death 3 🛚                        | Ectopic pregnanc  | Э                    |                     | 23d. Dat  | te of deliver           | y<br>Day Year                             |  |
| . <b>G</b><br>he dea   | Jysic           | 1 Yes 2 No 4 Pregnar<br>9 Unknown 9 Unknow   |   | Other (specify)   |                      |                     |   |                         | , ay                                      |  |
| cords, P.O. law requires that the las been signed by the 2 should be detach  | by P            | Part II. Other significant conditions contributing to deaf   | h but not resulting in the u                  | underlying cause giv  | ven in Part I.       | 23e. Did to         | bacco use contr   | ibute to the            | cause of death?                           |  |
| dS,<br>quires<br>en sig<br>ould b  |                 |  |   |   |                      | 1 🗆 1               | Yes 2 No  | 3 🗌 Proba               | ably 4 🗆 Unknown                          |  |
| COC<br>aw red<br>as be   | Completed       |  |   |   |                      | 24a. Was a          | sy p  | rior to com             | sy findings available pletion of cause of |  |
| The The page   |                 |  |   |   |                      | 1 🗆 Yes             |   | leath?                  | . □ No                                    |  |
| ISION Of VITAI RECORDS, Attending Physician: The law requires ar death. ector: After this certificate has been sig by the funeral director, page 2 should the  | Be              | 25. Was case referred to medical examiner?  1  Yes 2 No Hospital:  |   | Othe  | ace of Death (Chec   |                     |   |                         |   |  |
|  | e: To           | 27. Manner of Death 28a. Date of   |   | nt 3 🗆 DOA  | 4 U Nursing Ho       |                     | lence 6  Othe   |                         |   |  |
| tending<br>death.<br>tor: After<br>the fun   | licat           | 2 Accident Investigation   | Day, Year) injury                             | M 1 🗆   | ?<br>Yes 2 🗌 No      |                     |   |                         |   |  |
| Division of the Hospital or Attending Properties after death.  The Funeral Director: After it ompletely filled in by the funeral   | al Certificate: | building,  | Injury - At home, farm, str<br>etc. (Specify) |   |                      | City or Tow         |   |                         |   |  |
| e Hospi<br>24 hou<br>e Funer<br>letely fil   | Medical         | 29a. Certifier (Check 2 Medical Examiner: On the basis   | of examination and/or inves                   | stigation, in my opinio                                     | on, death occurred a | t the time, date a  | nd place, and due   | to the caus             | e(s) and manner stated                    |  |
| <b>To the</b><br>within 2<br><b>To the</b><br>сотрlе   | ž               | only one) 3 Certifying Nurse Practitioner: To 29b. Signature and title of certifier                            | the best of my knowledge                      | e, death occurred at t                                      | he time, date and pl | ace, and due to the | he cause(s) and m   | anner as sta            | ated.                                     |  |
| FSFO   |                 | Mas Muleon M.  | 1   | 12  | 0718                 |                     | _   |                         |   |  |
| 1.110  |                 | 30. Name and address of person who completed cause of  | of death (Item 23a) (Type, I                  | Print)  | 1                    |                     | 84-19<br>ep 21  |                         |   |  |
| HIO  |                 | T Tordam, 2003 Le  | die My  | +100  | Armif                | des, R              | RA) 71  | 401                     |   |  |
| Segis  | trar            | 31. Date filed (Month APR 2 3 2012 32. R   | strar's Signature                             | back  | •                    | •                   |   |                         |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 2012<sup>Year</sup> Physician/ April Day McCracken Marion 17 6:00 AM Frank Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3380 Howard Drive Port Republic Calvert Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🕅 M 2 🗆 F 01/12/1938 ear 242-52-7052 **Director** North Carolina 74 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Calvert 1 Yes 2 No Port Republic 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3380 Howard Drive 20676 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Claims Manager Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Benjamin Franklin McCracken Bridget Frances Reece 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eulah McCracken / Wife 3380 Howard Drive Port Republic, Maryland 20676 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Letropolitian Crematory 4 Donation 5 Other (Specify) 04/18/2012 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, PA. Kyle S. Simons MO1206 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cance disease or condition Luna Medical resulting in death) Due to (or a) a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Examiner Due to (or as a consequence of): and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: ves, outcome of pregnancy 23b, Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregns
5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 X Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performe death? within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2X No Certificate: To ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 🗌 No Investigation Could not be Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the Certifying Nurse Practioner To the best of my knowledge, Jeath prounted at the time, date and place and due to their 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 105 Prince Frederick ARW) Pat 31. Date filed (Month, Day) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 18, 2012 Year Physician/ Nathan William Moler 5:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 9496 Pocono Drive Frederick If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Davs Hours Director 233-48-6583 80 1 ፟፟፟ M 2 □ F June 21, 1931 West VIrginia Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funera 21702 9496 Pocono Drive United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) the Claims Agent Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk.)Madge John Moler traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trae 9496 Pocono Dr., Frederick, MD 21702 Shirley Moler / Wife Pate 21, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 2012 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Mt. Olivet Cemetery Other (Specify) 4 Donation Frederick, Maryland 21. Signatur Funeral Se e Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, 23a. Part 1. Enter the disease of complications that caused shock, or heart failure. Let only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer 10 yrs. Immediate Cause (Final Physician/ disease or condition resulting in death) Multiple Myeloma Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence or): attending physician and I for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has death? performe Yes 2 X No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: မြ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending ours after death. Ieral Director: Aff filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 X Certifying Physician: To 29a. Certifier he best q my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Funer completely fi examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner basis o actitioner: To Certifying Nurse P. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31912 April 18, 2012 death (Item 23a) (Type, Print) 30. Name and address of person who completed cause

State

Registrar

Julio Menocal, M.D.

ADD 9 1 2019

31. Date filed (Month, Day, Year)

32. Redistrar s Sig

110 Baughmans Lane, Suite 140, Frederick, MD 21702

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible

|             |  |  | 1      | For State Registrar   | State o   | of Marylar   |   | artmen<br>tificate                     |                                    |                            | and M                 | ental Hy                                | giene<br>Reg. No.                | 2012                                     | 2 1454   |
|-------------|--|--|--------|---|---|--|---|--|------------------------------------|----------------------------|-----------------------|---|----------------------------------|--|--|
|             |  | sician/  | /      | Decedent's Name (First, Middle, Judith Ann Nigh   |   |  | -   |  |                                    |                            |                       | 2. Date of De<br>Month<br>April         |                                  | Year                                     | 3. Time of Death 1:00 P M                          |
|             | -Printers  | ledical<br>aminer  | 4:     | a. Facility Name (if not institution, of Shady Grove Adv  | give street and nun                                       | nber)<br>Ospital   |   |  | Town, or                           | Location o                 | of Death              | APIII                                   | 4c. Co                           | unty of Death                            | 1 2 0 0 2  |
|             | Fune<br>Direc  | tor  |        | Social Security Number 215-60-7467  Usual Residence of Decedent   | 3. Sex<br>1 ☐ M 2 🛣 F                                     | 7. Age (In yrs.  | last birthday)<br>63 Yrs.                           | If Under<br>Months                     | 1 Year<br>Days                     | If Under<br>Hours          |                       | 8. Date of Bir<br>(Month, Da<br>Dec . 2 | th<br>ay, Year)<br>1948          |  | place (State or Foreign<br>ntry)<br>ington, DC     |
|             | laryland   | med at   |        | Oa. State 10b. County  Maryland Freder  | ick   |  | ty, Town or Local                                   |  |                                    |                            |                       |   |                                  |  | 10d. Inside City Limits 1 ☐ Yes 2 🛣 No             |
|             | with the N   | er must be notified at   | 1      | De. Street and Number  3036 Averley Ro  | ad  |  |   | 10f. Zip                               | Code 2175                          | 4                          |                       |   | 9                                | of What Cou                              | •  |
|             | Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  | Examiner mu  | 2      | Marital Status     Never Married 2  Marrie     Widowed 4 □ Divorced   | Armed Fo  | 2 🙀 No<br>re   |   | Vas Deced<br>Yes, spec                 |                                    |                            |                       | ify Yes or No-<br>ican, etc.)           | 14.                              | Race - Ameri<br>Black, White,<br>cify: W |  |
| Z           | Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o  | the Medical Exa  |        | 15. Decedent<br>(Specify only highes:<br>Elementary/Secondary (0-12)  | 's Education  | )  | life. Do  | lent's Usua<br>dind of wor<br>DNOT use | k done d<br>retired)               |                            | t of workin           | g                                       |                                  | of Business/Ir                           | on Company   |
| Judith      | land 2<br>be filed w<br>fental Hygi<br>rked other  | To Re  |        | 7. Father's Name (First, Middle, La<br>Augustus Gerry   | st)   | 2,476  |   |  |                                    |                            |                       | (First, Middle,                         |                                  |  | 1  |
| J.          | , Mary<br>nd 2 should<br>saith and N<br>n 27 is ma   | er trauma  |        | 9a. Informant's Name/Relationship<br>Michael Peter N  |   | (Spous<br>le   | 19b. Mailin<br>3036                                 | g Address<br>Aver                      | (Street a                          | nd Numbe                   | er or Rural<br>, Ija: | Route Numbe                             | er, City or Tow                  | n, State, Zip<br>yland                   | Code)<br>21754                                     |
| ightingale, | Baltimore, permit. Page 1 and Department of Hea  | ury or oth   | 2      | Da. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 🖾 Other (Sp   | 3 □ Removal from<br>ecify) Entom                          | State Dment F  | Place of Dispo<br>cemetery, cren<br><b>t</b> . Linc | sition (Nan<br>natory or o<br>coln     | ne of<br>ther place<br><b>Ceme</b> | tery                       | Apri<br>20            | 1 25,<br>12                             |                                  | on - City or T                           | own, State<br>Maryland                             |
| 于山土         | Balt<br>permit.<br>Departi<br>Import   | any inj  |        | 1. Signature of Funeral Service Lic   |   | м00689   | 10  | ) Eas                                  | t De                               | er Pa                      | ark D                 |   | Gaithe                           | -  | , MD 20877   |
| 2           | Physici  |  | 1      | 23a. fart 1 F far the disease, or c<br>spock, or propriational<br>mmediate Cause (Final<br>disease or condition             | ly one cause on ea  | ich line.<br>eless E                                       | lectri  |  |                                    |                            | cardiac or            | respiratory a                           | rest,                            |  | Approximate<br>Interval Between<br>Onset and Death |
|             | Medi<br>Exami  | ner  |        | resulting in death) Sequentially list conditions,   | Resp  | (or as a conseq<br>iratory<br>(or as a conseq              | Failu   | re                                     |                                    |                            |                       |   |                                  |  |  |
|             | executed<br>an and   | Fxaminer   | Type I | f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | <sub>c</sub> Flui   | d Overl  | oad   |  |                                    |                            |                       |   |                                  |  |  |
|             | Sicis  |  | 2      |   |   |  |   |  |                                    |                            |                       |   |                                  |  |  |
|             | Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate b 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physical principle in both a former of investor and a should be deaded for use of the physical physi | page z snould be detached for use as in Completed by Physician/Med | IF 2   | FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🛣 No 9 □ Unknown   | 1 Live  | tcome of pregna<br>Birth 2  Fet<br>nant at time of<br>nown | al death 3  | Ectopic p<br>Other (sp                 |                                    | у                          |                       |   | 23d                              | Date of delive                           | very<br>Day Year                                   |
|             | S, P.O. Bc<br>ires that the dea<br>signed by the a   | d by Ph  | E F    | art II. Other significant condition   |   |  |   |  |                                    | en in Part                 | I.                    |   |                                  |  | the cause of death?                                |
|             | Records, the law require te has been si  | oage z snou  |        | Diabetes Mell   | itus; Ca  | rdiomyo  | pathy   |  |                                    |                            |                       |   |                                  | prior to or death?                       | opsy findings available ompletion of cause of      |
|             | f Vital Reco Physician: The law this certificate has be  | To Be C  | 2      | 5. Was case referred to medical examiner? 1 ☐ Yes 2 🂢 No  | Hospital:   | Inpatient 2  | ER/Outpatier  | nt 3 🗆 DO                              | Other                              | ace of Dea                 |                       |   |                                  |  |  |
|             | on of<br>ending Ph<br>eath.<br>or: After th  | <u> </u>   | 2      | 7. Manner of Death  1 Natural 5 Pending 2 Accident Investiga  | 28a. Date<br>(Mon   |  | 28b. Time of injury                                 |  | 8c. Injury<br>work                 | at                         | 2                     | 8d. Describe                            |                                  |  |  |
|             | Division ital or Attendir urs after death.   | Certification  |        | 3 ☐ Suicide 6 ☐ Could not determine   | 28e. Place  | of Injury - At h   |   | et, factory                            | , office                           |                            | 2                     | 8f. Location (<br>City or To            |                                  | mber or Rura                             | al Route Number,                                   |
|             | Div<br>To the Hospital or<br>within 24 hours aff<br>To the Funeral Di  | Medical  |        | (Check 2 Medical Exonly one) 3 Certifying   | Physician: To the baminer: On the ba<br>Nurse Practitione | sis of examination   | on and/or invest                                    | igation, in death occ                  | my opinio<br>urred at th           | n, death oo<br>ne time, da | ccurred at            | he time, date                           | and place, and<br>the cause(s) a | d due to the cand manner as              | ause(s) and manner stated stated.                  |
| 4           | 5 × 5 × 5  | 2  |        | 9b. Signature and title of certifier  | W.  |  |   |  | License                            | 502                        |                       |   |                                  | gned (Month,                             |  |
| •           |  |  |        | O. Name and address of person w<br>Brian Anthony C  | arpenter  | , M.D.,  | 9901  | Medic                                  |                                    | ente:                      | r Dri                 | ve, Ro                                  | ckvill                           | e, MD                                    | 20850  |
|             | Reg  | State<br>gistrar   | 3      | 1. Date filed (Month, Day, Year)  | 2012  | Registrar's Signa  | A. A.   | أقسك                                   |                                    | ·                          |                       |   |                                  |  |  |

Registrar DHMH 17 Rev 06-2011

|   |                  | Plea   | se Type                    |   |  |  |                                      |                     |                            |                       | -                                    |           | _                 | jible.                  |                           |   |
|---|------------------|--|----------------------------|---|--|--|--------------------------------------|---------------------|----------------------------|-----------------------|--------------------------------------|-----------|-------------------|-------------------------|---------------------------|---|
|   |                  | For State  | State                      | e of M                                    | arylan                                       |  |                                      |                     |                            | and N                 | 1ental Hy                            | /gien     | e                 | ^ I 6                   | ,                         |   |
|   |                  | Registrar  1. Decedent's Name (First, Middle   | , Last)                    |   |  | Cel                                    | rtifica                              | e or L              | <i>Jeatn</i>               |                       | 2. Date of De                        | Reg. N    | lo                |                         | 3 11                      | me of Death                                 |
| Physicia<br>Medic   | al               |  | Thanh Ni                   |   | u Ngi  | ıyen                                   |                                      |                     |                            |                       | April                                | 1         |                   | 2012                    |                           | 1:45 pM                                     |
| Examin  | er               | 4a. Facility Name (if not institution, 10214 Feaga   | Farm Co                    | wrt                                       |  |  |                                      | ł                   | Location of Ellic          |                       | City                                 | 4         | c. County         | Н                       | owar                      |   |
| Funeral<br>Director   |                  | 5. Social Security Number 586-52-6124  | 6. Sex<br>1 ☐ M 2 <b>X</b> | _   | e (In yrs. Ia<br>8 0                         | st birthday)<br>Yrs.                   | If Unde<br>Months                    | Days                | If Under<br>Hours          | 24 Hrs.<br>Min.       | 8. Date of Bi<br>(Month, Da<br>March | ay, Year) |                   | Coul                    | place (S<br>ntry)<br>iet/ | state or Foreign                            |
| tnd<br>thow<br>at   | ō                | Usual Residence of Decedent  10a. State  10b. County   |                            |   |  | , Town or Lo                           | cation                               |                     | L                          |                       | Materi                               | 41,1      | 1932              |                         |                           | ide City Limits                             |
| Maryla<br>28a-f   | irect            |  | ward                       |   |  |  |                                      |                     | icott                      | Cit                   | у                                    |           |                   |                         | 1 🕽                       | Ves 2 □ No                                  |
| with the 23a or   | Funeral Director | 10e. Street and Number  10214 Feaga  | Farm Co                    | wrt                                       |  |  | 10f. Zi                              | p Code              | 210                        | 42                    |                                      | 10g. C    | Citizen of        |                         | ntry?                     |   |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.                                | by Fun           | 11. Marital Status 1 □ Never Married 2 🕱 Marr  | 12. Was I                  | Decedent 8<br>d Forces?<br>Yes 2 <b>X</b> |  | 13.                                    | Was Dece<br>f Yes, spe               | dent of Hi          | spanic Oriç<br>n, Mexican  | gin? (Spe<br>, Puerto | cify Yes or No-<br>Rican, etc.)      | -         |                   | e - Ameri<br>ck, White, |                           | an,   |
| urs afte<br>tural", c<br>al Exam  | ted b            | 3 🗆 Widowed 4 🗆 Divorced   | If Yes<br>Year             | res 2 <b>&amp;</b><br>, Give<br>or Dates. | NO   |  |                                      |                     | Specify:                   |                       |                                      |           | Specify           | :                       | Asia                      | in  |
| 72 ho<br>in "nat<br>Medica  | Completed        | (Specify only highe  | 1                          |   |  | 16a. Deced<br>(Give                    | dent's Usu<br>kind of wo<br>O NOT us | rk done d           | ation<br><i>uring most</i> | of worki              | ng                                   |           | Kind of B<br>Howa |                         |                           | u   |
| within<br>/giene.<br><b>ner tha</b><br><b>t, the f</b>  |                  | Elementary/Secondary (0-12)  | Colleg                     | ge (1-4 or 5<br><b>5+</b>                 | 5+)  | Commu                                  |                                      | ,                   | rer-S                      | ecti                  | on 8                                 |           | Gove              |                         |                           |   |
| e filed<br>ntal Hy<br>ed oth  | To Be            | 17. Father's Name (First, Middle, L.   | <sup>ast)</sup><br>Xan N   | laa Uu                                    |  |  |                                      |                     | 18. Mothe                  | er's Name             | (First, Middle                       |           |                   | *                       |                           |   |
| ould b<br>nd Me<br>mark<br>mark   |                  | 19a. Informant's Name/Relationsh   |                            | go vi                                     | <u>.                                    </u> | 19h Mailir                             | na Addres                            | s (Street a         | and Numbe                  | r or Rura             | Hoang  I Route Numbe                 |           |                   |                         | Cade)                     |   |
| nd 2 sh<br>ealth a<br><b>n 27 is</b><br>er trau   |                  | Hai Dang Nguye   | n - Spo                    | use                                       |  | 1                                      | -                                    |                     |                            |                       |                                      |           |                   |                         | ,                         | nd 2104                                     |
| ige 1 ar<br>nt of Ha<br>t: If iter  |                  | 20a. Method of Disposition  1  | 3 🗌 Removal f              | from State                                | CE   | lace of Dispo                          | natory or                            | other place         | · .                        |                       | Date                                 | 1         | Location -        | ,                       | ,                         |   |
| mit. Pa<br>partme<br>portan<br>/ injun,   | 1                | 4 ☐ Donation 5 ☐ Other (S <sub>1</sub> 21. Signature of Funeral Service Li   |                            |   | [Cre   |  |                                      |                     |                            |                       | 1/2012<br>01-Rina                    |           |                   |                         |                           | <u>MV</u><br>e, Inc.                        |
| a II De   |                  | 59 Wh  | -ma                        | 129                                       | 4  | 11                                     | 800                                  | New t               | lamps                      | hire                  | Ave., S                              | Silv      | er S              | prine                   | 3, MD                     | 20904                                       |
| Physician/<br>Medical<br>Examiner   |                  | 23a. Part 1. Enter the disease, or<br>shock, or heart failure. List of<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)  | nly one cause o            | n each line                               | tasta  | tic Lu                                 |                                      |                     |                            | cardiac o             | r respiratory a                      | rrest,    |                   |                         | Interva                   | ximate<br>al Between<br>and Death<br>Months |
| g   | dical Examiner   | i i  |                            |   |  |  |                                      |                     |                            |                       |                                      |           |                   |                         |                           |   |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physicing ampletely filled in by the funeral director, page 2 should be detached for use as the but the funeral director. | ~                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)  |                            |   |  |  |                                      |                     |                            |                       |                                      |           |                   | ery<br>Day              | Year                      |   |
| s that thighed by be deta   | ğ                | Part II. Other significant conditio  | ns contributing            | to death b                                | ut not resu                                  | ulting in the u                        | nderlying                            | cause give          | en in Part I               |                       |                                      |           |                   |                         |                           | e of death?                                 |
| require<br>been si<br>should  | eted             | -  |                            |   |  |  |                                      |                     |                            |                       |                                      |           |                   |                         |                           | 4 Unknown ings available                    |
| nysician: The law<br>nis certificate has t<br>I director, page 2 s  | Completed        |  |                            |   |  |  |                                      |                     |                            |                       |                                      |           | 1                 |                         | mpletion                  | n of cause of                               |
| sician:<br>certific<br>irector  | Be               | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No   | Hospital:                  |   |  |  |                                      | Othe                | ce of Deat                 |                       |                                      |           |                   |                         |                           |   |
| ing Phy<br>I.<br>After this<br>funeral d  | ate: To          | 27. Manner of Death  1   ✓ Natural 5 □ Pending   | 28a. D                     | ☐ Inpatie<br>Pate of injuited Month, Day  | ry I   | ER/Outpatier<br>28b. Time of<br>injury | 2                                    | 8c. Injury<br>work? | 4 L Nu<br>at<br>>          | 2                     | me 5 🗶 Resi<br>28d. Describe I       |           |                   |                         | 2                         |   |
| the Hospital or Attending Ph<br>thin 24 hours after death.<br>the Funeral Director. After th<br>mpletely filled in by the funeral   | Il Certificate:  | Accident Investigation Suicide Good Could not be determined learning by the following of th |                            |   |  |  |                                      |                     |                            |                       |                                      |           |                   | er or Rura              | Route I                   | vumber,                                     |
| e Hospi<br>24 hou<br>e Funer  | Medical          | 29a. Certifier (Check 2 Medical Exonly one) 3 Certifying   | caminer: On the            | basis of e                                | xamination                                   | and/or invest                          | igation, in                          | my opinio           | n, death oo                | curred at             | the time, date a                     | and plac  | e, and due        | e to the ca             | use(s) an                 | id manner state                             |
| Withir #  |                  | 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, I   |                            |   |  |  |                                      |                     |                            |                       |                                      |           | Day, Yea          | ,                       |                           |   |
|   |                  | 30. Name and address of person of  | no completed               | cause of de                               | eath (Item                                   | 23a) (Type, P                          |                                      |                     | D3876                      |                       |                                      |           |                   |                         |                           |   |
| State   |                  | Sharon J. McC 31. Date filed (Month, Day, Year)  |                            |   |  |  |                                      | deric               | ck Roo                     | ad,                   | #18, Bo                              | uti       | more,             | , MD                    | 212                       | 29  |
| Registra  |                  | APR 232  | 2012                       | exer                                      | م ر  | . pa                                   | مسكر                                 |                     |                            |                       |                                      |           |                   |                         |                           |   |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIL 22, 2012 Year OTTILIE ALMA NEELY 2:00 P M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 122 SOMERSET ROAD STEVENSVILLE QUEEN ANNE'S Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Director 215-01-5043 1 □ M 2 🔀 F 96 Vrs 1916 Usual Residence of Decedent APRIL 14, MARYLAND or 28a-f shov 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 No MARYLAND QUEEN ANNE'S STEVENSVILLE 10e, Street and Number 10g. Citizen of What Country? must be Funeral 23a 122 SOMERSET ROAD 21666 UNITED STATES Id Mental Hygiene.
marked other than "natural", or iten 1. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Yes. Give 3 Xwidowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) OFFICE MANAGER CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file f Health and Mental I ttem 27 is marked o ၉ GEORGE BELTZ OTTILIE DIETRICH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 SOMERSET ROAD, STEVENSVILLE, MARYLAND 21666 RONALD NEELY/SON item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of i
Important: If it
any injury or o
once. APRIL 23 1 Burial 2 XCremation 3 Removal from State CHESAPEARE CREMATION CENTER 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MARYLAND 2012 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Oncet and Death Physician/ Medical Examiner 6 M Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: fyes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav Pregnant at time of death 5 Other (specify) signed by the a P.0. Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform page certificate 1 Yes 2 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 5 Pending Accident Investigation 3 🔲 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated. only one 29b. Signatu certifie

State Registrar

DHMH 17 Rev 06-2011

30. Name and add

31. Date filed (Month, Day, Year)

APR 2 4 201

erson who completed cause of death (Item 23a) (Type, Print) Shows Drive

32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

68760

Box (

P.O.

of Vital

Division

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

|   | _1   | For<br>State<br>Registrar  |                              | State   | of Mary  | /land  |                    | artment o  |                          |                      | nd M                 | lental Hy                       | gien<br>Reg. N | 21                           |                    | 2   1                                   | +54       |
|---|--|--|------------------------------|---|--|--|--------------------|--|--------------------------|----------------------|----------------------|---------------------------------|----------------|------------------------------|--------------------|---|-----------|
| ysician<br>Medica   |  | 1. Decedent's Nam<br>Murray  | e (First, Middl<br>Paul      | e, Last)  |  |  |                    |  | -                        |                      |                      | 2. Date of De<br>Month<br>April | ath            | ay                           | Year<br>2012       | 3. Time o                               | of Death  |
| xamine  | er   | 4a. Facility Name (ii<br>Arbor Plac  |                              | n, give street and n  | umber)   |  |                    | 4b. City, Town<br>Rockvil                                |                          | ation of             | Death                |                                 | 1              | c. County of                 |                    | 1                                       |           |
| neral<br>ector  |  | 5. Social Security N<br>096-20-479   |                              | 6. Sex  | 7. Age (In   |  |                    | If Under 1 Ye Months Day                                 |                          | Under 2              | 4 Hrs.<br>Min.       | 8. Date of Bir<br>(Month, Da    |                |                              | 9. Birt            | hplace (State outry)                    | or Foreig |
|   |  | Usual Residence<br>10a. State  | of Decedent                  |   |  |  | Yrs.               |  |                          |                      |                      | May 11,                         | 1927           |                              | New                |   |           |
| offfied   | Director   | MD MD  | Montgo                       |   |  | Rockvi   | own or Loc<br>ille | cation   |                          |                      |                      |                                 |                |                              |                    | 10d. Inside C                           |           |
| agt be n  |  | 10e. Street and Nur<br>4413 Munca  |                              | 1 Rd.   |  |  |                    | 10f. Zip Cod<br>20853                                    | е                        |                      |                      |                                 | 7.5            | Citizen of W                 | /hat Co            | untry?                                  |           |
| 뒽   | d by Funeral   | 11. Marital Status  1  Never Marital Status  | ried 2 🗆 Mar                 | 12. Was De<br>Armed<br>1 \( \bar{\Delta} \) Ye<br>If Yes, (     | cedent Ever<br>Forces?<br>s 2 D No<br>Give<br>Dates. Arm |  | li li              | Vas Decedent of Yes, specify C                           | ıban, Me                 | exican,              | in? (Spe<br>Puerto I | cify Yes or No-<br>Rican, etc.) |                | 14. Race                     | k, White           |   |           |
| Medical   | Completed  |  | 15. Decede                   | ent's Education<br>est grade complete                           | ed)  | 4  | (Give I            | lent's Usual Oci<br>kind of work doi<br>O NOT use retiri | e dunng                  |                      | of workii            | ng                              | 16b.           | Kind of Bu                   | siness/            | Industry                                | ·         |
| vent, the   | Be   | 17. Father's Name  |                              |   | (1-4 or 5+)  | I  | Physic             | ian  | 18.                      | Mother               | 's Name              | e (First, Middle,               | _              | diatri<br>n Su <i>mame</i> , |                    |   |           |
| atic e  | ᅀ  | Harry Paul   |                              |   |  |  |                    |  | Na                       | aomi                 | Kapl                 | an                              |                |                              |                    |   |           |
| traum   |  | 19a. Informant's Na<br>Mitchell  |                              |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24305 Empress Court Gaithersburg, MD 20882 |                    |  |                          |                      |                      |                                 |                |                              |                    |   |           |
| othar   |  | 20a. Method of Dis   | position                     |   | 2  | 20b. Place   | e of Dispo         | sition (Name of  |                          | Gait                 |                      |                                 |                |                              | City or            | Town, State                             |           |
| lury or   |  | 20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cermetery, crematory or other place)  King David  04/22/2012  Falls Church  |                              |   |  |  |                    |  |                          |                      |                      |                                 |                | rch,                         | VA                 |   |           |
| any in  |  | on the state of th |                              |   |  |  |                    |  |                          |                      |                      |                                 |                | ial Chap                     | els                |   |           |
| burlal-transit  | sal Examiner   |  |                              |   |  |  |                    |  |                          |                      |                      |                                 |                | wanti                        | Year               |   |           |
| complately filled in by the funeral director, page 2 should be detached for use as the burlai-transit |  | IF FEMALE:<br>23b. Was decedent<br>in the past 12<br>1 ☐ Yes 2 [<br>9 ☐ Unknowr  |                              | Ectopic pregn   |  |  |                    |  |                          | 23d. Date<br>Mor     |                      | ,                               | Year           |                              |                    |   |           |
| hould ba dat  | Completed by F   | Rewr   |                              | ons contributing to   |  | _  | ng in the u        |  | given in                 | n Part I.            |                      |                                 |                | 2 🗆 No                       | 3 🗆 Pr             | the cause of o                          | Unkno     |
| or, paga 2 s  |  | OF Was seen of   |                              |   |  |  |                    |  |                          |                      |                      | 1 🗆 Yes                         |                | p<br>d                       | nor to o<br>leath? | opsy findings<br>completion of<br>2  No |           |
| diracto   | To Be  | 25. Was case reference examiner? 1 ☐ Yes 2   | red to medical               | Hospital:   | ☐ Inpatient  | 2 [] EB  | (Outpation         | - 1  | Whor                     |                      |                      | only one) me 5 🗆 Resi           |                | . <b>7</b> 0                 | <b>6</b> 0         | ASSIS                                   | tel       |
| in by tha funaral   | Certificate:   | 27. Manner of Deat  1 Natural 2 Accident 3 Suicide 4 Homicide  | 5 Pendi                      | 28a. Da<br>(Mi<br>igation<br>not be<br>nined 28e. Pla           | te of injury<br>onth, Day, Ye                            | ear) 281   | b. Time of injury  | 28c. lr  | jury at<br>ork?<br>☐ Yes |                      | No 2                 | 28d. Describe I                 | now inju       | ary occurre                  | d                  | Li                                      | ber,      |
| mplataly fillar   | Medical  | (Check 2<br>only one)  | 2   Medical<br>3   Certifyin | g Physician: To the<br>Examiner: On the b<br>g Nurse Practition | pasis of exami   | ination an   | id/or invest       | igation, in my op<br>death occurred                      | inion, de<br>at the tin  | eath occ<br>ne, date | curred at            | the time, date a                | and plac       | e, and due                   | to the c           | ause(s) and m                           | anner st  |
| ē/  | 29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  April 19, 2013  30. Name and address of person with sampleted ause of death (Item 23a) (Type, Print) 3365 Worth Leiswe world Blud |  |                              |   |  |  |                    |  |                          |                      |                      |                                 |                |                              |                    |   |           |
| 6   |  |  |                              |   |  |  |                    |  |                          |                      |                      |                                 |                |                              |                    |   |           |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 23 Patel 2. 2108 M Miraxi 04 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University Baltimore at Mary 6 I Medical Center 4 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 338-66-8767 **Director** 1 M 2 X F 62 21.1949 India Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene. attriber 15 is marked other than "natural", or items 23a or 28a-f sho and if item 27 is marked other than "natural", or items 23a or 28a-f sho ury or orther traumatic event, the Medical Examiner must be notified at ury or orther traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** DE 1 Yes 2 No Kent Dover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Way 19901 Granite USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 🗷 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Asian Indian 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hotel Dwner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည atel Shantaben Shotambha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patel - tem. 14 Department of Health Important: If item 27 any injury or other trong. 155 Run. Camden. trienu Vining De 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4/27/12 4 ☐ Donation 5 ☐ Other (Specify) Capital Crematory Dover, Dulaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5. Bradford 61 Welliam Chaper Funeral Dover. 19904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** heunato Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury as the burial-trar and that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Li retail usa.
Pregnant at time of death in the past 12 months?

1 Yes 2 0

9 Unknown Day 5 Other (specify) Month Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe 1 Yes Yes 2 filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 Patient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death s after death. I Director: After the 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital or 24 hours Medical prtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number 4/23 2012 P27232 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 Baltimore MD St. MO 22 S. Greek 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 14547 Certificate of Death AJS 5/1/12 Reg. No. Amended #5 per fh CCHD Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $18^{\text{Day}}$ April Guy 20 Î 2 Maurice Pearson 08:45 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Queen Anne's Hospice of Queen Ann's Centreville Social Security Number 212-66-201 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F 0ct 17 1953 Maryland Director Yrs. 58 Usual Residence of Decedent show 10a. State 10b. County the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f Yes 2 No Maryland Caroline Greensboro ò 10e. Street and Number 10f. Zip Code Examiner must be 10g. Citizen of What Country? Funeral with 23a 717 W. Sunset Ave. 21639 USA items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, ed Forces Black, White, etc. ö ğ 1 Never Married 2 XMarried Yes Yes, Give 2 🗌 No 21215-0036 1 ☐ Yes 2 X No Specify: Black 'natural" Completed 3 Divorced 4 Divorced Year or Dates ed other than "natu event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Equipment operator Friel's Lumber Com Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ith and Mental H 27 is marked of traumatic ever ၉ Guy Pearson Lorraine Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Patsy L. Pearson wife 717 W Sunset Ave; Greensboro, MD 21639 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Apr 28 2012 Cokers Cemetery Greensboro, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 Fleegle and Helfenbein Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death ESOPHAGEAL disease or condition resulting in death) VARILUS Medical Examiner 9LCOHOLIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine ANCRUATITIS -tran and that initiated events resulting in death) Last Due to (or as a consequence of physician a sthe burial-Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month Day Year Yes 2 □ No 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been signed page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform After this certificate 1 Yes 2 No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: ၉ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Tother (Specify HE STILL & HEUS 27. Manner of Death 28a. Date of injury al or Attending P s after death. I Director: After t d in by the funera Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1. Natural 5 Pending Investigation 1 Yes 2 No Accident within 24 hours after de To the Funeral Directo completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier DG0 5750 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DENTON, 609 LACON, strar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14548 State of Ivial yian of State of Ivial yian of State Registrar Amended #2 per FH 4/20/12 Certificate of Death CCHD AJS Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death 4/16 /2012 Physician/ Carroll R. Pinkett Medical of Death Facility Name (if not institution, give street and number, cation of Death **Examiner** 4b. City 1 Ce AT If Under 24 Hrs Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours 216-56-0723 1 **X** M 2 □ F Director 60 Maryland June 22,1951 Yrs. Usual Residence of Dece or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Dorchester Federalsburg 1 Yes 2 No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? and Mental Hygiene.
is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be r 21632 United States 6860 Reliance Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2x Married HRRoll / M Maryland 21215-0036 ☐ Yes 2 🙀 No If Yes, Give Year or Dates Black 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) B & G Company Foreman 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Elizabeth Parker Emerson Harrington Pinkett Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose M. Pinkett/Spouse P.O. Box 394, Federalsburg, MD 21632 Baltimoré, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Federalsburg, Maryland Federal Hill Cemetery 04/20/12 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. ici.n. CA LUNG disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atter in the past 12 months? Dav Year Month Pregnant at time of death
Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No Physician: director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Other (Specify) 21 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral ( 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending thin 24 hours after death. Natural 5 Pending work 1 Tes 2 🗌 No the f Accident Investigation 6 Could not be Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 24 hours Medical tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Sign State APR 19 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4 2012 <u>Jacob Frederick Panetti</u> 11:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 151 Island View Dr. Annapolis Anne Arundel . Social Security Number 6. Sex 1 2 M 2 D F If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) Days Hours 3/6/192Director Yrs 213-28-5156 85 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Tes 2 X No MD Anne Arundel Annapolis 10e. Street and Number þ 10f. Zip Code 10g. Citizen of What Country? ural", or items 23a or Examiner must be Funeral 151 Island View Dr 21401 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No 1945—
If Yes, Give
Year or Dates. 1946 Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify. Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Salesman and Mental Hygie is marked other Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev 2 Jacob F. Panetti, Jr. Catherine Homfeldt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Island View Dr., Margaret Panetti / Wife 151 Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/23/2012 | Baltimore, MD Loudon 21. Signatura of Juneral Septice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home de 1 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ DEMENTIA Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 2/2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 1 📐 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gordfying Nurse Pranticiner: To the bond of my knowledge, coath cooping at the time, date and place, and due to the cause(s) and normer as stated. (Check 29b. Signature and title officertifie 29c. License number 29d. Date signed (Month, Day, Year) 0*5665* & 20,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smite 400. TITUS Highway Annapolis ABIZAHAN 31. Date filed (Month, Day, Year) APR 2 3 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2140 Mahindra Persaud 2012 April Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours 218-31-3506 67 Guuana Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Takoma Park 1 Yes 2 No Maryland Montgomery 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral U.S.A. 20912 7904 Cole Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. by 1 Never Married 2 Married Yes 2 X No 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Asian Indian 3 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Parbatie Rai Shivnauth Persaud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7904 Cole Avenue, Takoma Park, Maryland 20912 Sankar Persaud - Son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State Lincoln Crematory 04/21/2012 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc 11800 New Hampshire Ave., Silver Spring, MD 20904 e of Funeral \$ rvic Licknses 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary Artery Atherosclerotic Physician/ disease or condition ) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, by the attending physician and Examine Due to for as a consequence on if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should he death. Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 2 🗌 No ျင 1 ☐ Inpatient 2 区ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signa ure and title of certifier 4-19-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lightfoot, Jr., M.D., 20010 Century Blvd., Germantown, Maryland 20874 Kennedy James 31. Date filed (Month, Day, Year) State APR 23 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month  $20^{\text{Day}}$ Physician/ 201°2 10:44A M Eugene John Joseph Picasso Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Berlin Worcester Atlantic General Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) NJ Funeral 1 🛛 M 2 🗆 F Days Hours Min. 1/5/1917 l065-09-8208 95 Yrs Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State with the Maryland Director must be notified 1 ☐ Yes 2X No MD Ocean Pines Worcester 9 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 71 Battersea Dr. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☒ No Specify: Specify: white 3₺ Widowed 4 □ Divorced injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Navy U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Agostina DeFerrari Joseph St. Louis Picasso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Easton Ave., Ocean Pines, MD 21811 Jerry Richards / friend 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State State Crem. 4/23/2012 Millsboro, DE 4 Donation 5 Dether (Specify) First 22. Name and Address of Facility Burbage Funeral Home Service License 108 William St., Berlin, MD 21811 23a. Part 1. Ent 3 In diseas, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on enterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) neamonio Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 1 Yes 2 9 Unknown been signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has base 2 s autonsy ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita Other: 1 ☐ Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2, To the F only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)0064120 and address of person who completed cause of death (Item 23a) (Type, Print) Berlin RA 10+1 AGH 9733 Health Way

State Registrar 31. Date filed (Month, Day, Year)

30

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $2012^{\text{Year}}$ DANUTA WIESLAWA REKAWEK April  $\mathbf{A}^{\mathsf{M}}$ 9:35 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Potomac Valley Nursing Center Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, Hours Min. 147-30-5682 **Director** 1 □ M 2 **X** F 87 May 3, 1924 Poland 28a-f show items 23a or 28a-f shoner must be notified at filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😿 No Maryland Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? Funeral 11228 Green Watch Way 20878 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. "natural", or 1 Never Married 2 Married ģ ☐ Yes 2 **X** No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 X Widowed 4 Divorced Specify: White Completed Year or Dates marked other than "natur matic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemaker Own Home other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marian Hawran Janina "Unknown" 1 and 2 should f Health and N item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Smink (Daughter) 11228 Green Watch Way Gaithersburg, MD 20878 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 26, cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Our Lady of Czestochowa 4 ☐ Donation 5 ☐ Other (Specify) Doylestown, PA 2012 Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home tis 3 (M01116)10 East Deer Park Dr. gaithersburg, MD 20877 23a. Part 1. Enter the disease, or contribications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death th, sician Cardiopulmonary Arrest Medical resulting in death) Due to (or as a consequence of) Examiner Advanced Dementia Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Failure to Thrive tran and Due to (or as a consequence of) attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 the signed by t d be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 Yes 2 No ☐ Yes 2 😾 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 🔀 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director, After thi funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending work?
1 Yes 2 No X Natural Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cq 29c. License number 29d. Date signed (Month, Day, Year) 6 D69148 April 23, 2012

Registrar
DHMH 17 Rev 06-2011

State

10110 Molecular Dr. #206 Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Marichu Theresa Matas M.D.

Year)

APR 2 4 2012

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 14554 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ April 1442M 2012 Eileen Louise Rider Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Hagerstown Washington Social Security Number If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Min (Month, Day, Year) Jan. 25, 1933 Director 217-28-2207 79 Maryland Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location notified at Director 1 Yes 2 No MD Washington Hagerstown 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be items 23a Funeral 1135 Potomac Avenue 21742 U.S.A. hours after death 12 Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 9 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify 'natural", Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Food and Beverage Owner/Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic even ပ Viola Wolf Ragan Shaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1135 Potomac\_Avenue, Hagerstown, MD 21742 Kathy Persinger / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Rest Haven Cemetery 4/27/2012 Hagerstown, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_si\_ian/ Sepsi disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Exterior litis 5 Sequentially list conditions, if any, leading to in insulate cause. Enter Underlying Examiner burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician Diseas Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Day 5 Other (specify) Month Year Pregnant at time of death ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed l ջ Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an cate has l autopsy certificate Yes Division of Vital 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After iniury 1 Matural 5 Pending work?
1 Yes 2 No 24 hours after death. Funeral Director; A Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D060396 04 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 opal TW-lo 21740 FARID CM exstil y 1100 31. Date filed (Monti Raistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 20 April 2012 A  $^{\text{M}}$ 6:30 Anna P. Rosario Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Heritage Harbour Health and Rehab. Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Hours 105-16-5717 96 **Director** 1 🗆 M 2 🕱 F March 7, 1916 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD <u>Bowie</u> Prince George's 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2405 Panther Ln. USA "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married þ Maryland 21215-0036 Yes 2 😿 No If Yes, Give Year or Dates Specify: White 1 Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) the Secretary State of Maryland Be 17. Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed the alth and Mental Hitem 27 is marked ot ပ Constantine Panos Helen MacCrakey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 JoAnne Powell / Daughter 2405 Panther Ln., Bowie, MD 20716 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State of Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4/21/2012 4 Donation 5 Other (Specify) Edgewater, MD Crematory 21. Signature of Funeral Service Lic 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, 12 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure/List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 2 No 1 Yes 25. Was case referred to medical Division of Vital Hospital or Attending Physician: 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 — Natural 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: A Accident Investigation 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physican: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiles: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Name and address of person who completed cause of death (Item, 23a), (Type, Print) 31. Date filed (Month, Day, Year) APR 23 2012 egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| 12-03073   |  | Print in Black Ir                                   |                                 |  |  | ble.                                 |   |
|--|--|---|---------------------------------|--|--|--------------------------------------|---|
|  | 1- For State Registrar   | of Maryland / Depa                                  | rtificate of Deat               |  | Reg.   |                                      | 2 1455  |
| Physician/   | Decedent's Name (First, Middle,Last)                                       |   |                                 |  | 2. Date of Death<br>Month D<br>April 20, 201 | ay Year                              | 3. Time of Death<br>0906 hrs                            |
| Medical Examiner   | Terry Clarke Ros  4a. Facility Name (if not institution, give              |   | 4b. City.                       | Town, or Location of De                              |  | 4c. County of Death                  |   |
|  | Shady Grove Adventist Hos  |   | Rock                            |  |  | Montgomery                           |   |
| Funeral<br>Director  | 5. Social Security Number 6. Sex 215-48-3429                               | 7. Age (In yrs.                                     | Manti                           | ler 1 Year   If Under 24                             | Hrs. 8. Date of Birth (1971)                 | MM/DD/YYYY) 9. Birt<br>Foreig<br>Cou | hplace (State or<br>Washington,<br><sup>untry)</sup> DC |
| gus  | Usual Residence of Decedent  10a. State 10b. County                        | 10c. City   | , Town or Location              |  |  |                                      | 10d. Inside City Limits                                 |
| E I  | MD Montgome  | erv G   | ermantown                       |  |  |                                      | 1 Yes 2 X No  |
| the Maryland<br>a or 28a-f sh<br>tified at onc<br>Director   | 10e. Street and Number   |   | 10f. Zij                        |  | 1  | Citizen of What Cour                 | -   |
|  | 13604 Hartsbouri   | ne Dr.  |                                 | 0874   |  | nited State                          |   |
| r death with<br>or items 23.<br>must be no<br>Funeral  | 11. Marital Status  1 Never Married 2 X Married                            | 12. Was Decedent Ever in U<br>Armed Forces?         |                                 | ent of Hispanic Origin? (<br>ify Cuban, Mexican, Pue |  | 14. Race - Ameri<br>White, etc.      | can Indian, Black,                                      |
| ter dea  |  | 1 Yes 2 No  | 1 Yes 2                         | X No specify:  |  | Specify: Whit                        | te  |
| ours aft ntural" namine  | 15. Decedent's Education (Specify onl                                      | or Dates:   |                                 | Dccupation (Give kind                                |  | 6b. Kind of Business/li              | ndustry   |
| 6<br>172 ho<br>ran "na<br>cal Es   | Elementary/Secondary (0-12)  | College (1-4 or 5+)                                 | ľ                               | rking life. DO NOT use                               | retired)                                     | D. 11 1 4 a 1                        | Education   |
| 5-0036 ed within 72 hour ed within 72 hour other than "natu the Medical Exan Completed   | 17. Father's Name (First, Middle, Last)                                    | 5   | Educator                        | 18 Mother's Na                                       | me (First, Middle, Mai                       |                                      | Education   |
| 215-<br>be filed<br>that Hy<br>rked of<br>cnt, the   | Mark Harry Ross  | sen   |                                 |  | othstein                                     | ,                                    |   |
| Baltimore, MD 21215-0036 sernit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than njury or other traumatite event, the Medica To Be Comple   | 19a. Informant's Name/Relationship (Ty                                     |   | 19b. Mailing Addres             | s (Street and Number                                 |  | er, City or Town, State              | Zip Code)   |
| MD id 2 sh ulth an ulth an a 27 i  |  | Spouse  | 13604 Ha                        | rtsbourne D  | r., German                                   | ntown: MD 20                         | 0874  |
| ore,<br>es 1 ar<br>of Her<br>of Her<br>frite   | 20a. Method of Disposition  1 Burial 2 X Cremation 3                       |   | crematory or other place        | )  |  |                                      |   |
| timent trans   | 4 Donation 5 Other Specify:  |   | Atlantic Cre                    |  |  | Glen Burn                            |   |
| Ball<br>permi<br>Depar<br>Impo   | 21. Signature of Funeral Service Livens                                    | M00956  |                                 | k Avenue, G  |  |                                      | rvice, P.A.   |
| Physician  | 23a. Part I. Inter the disease, or compli                                  | cations that caused the death                       | n. Do not enter the mode        | of dying, such as cardia                             | c or respiratory arrest                      | , shock, or heart                    | Approximate Interval<br>Between Onset and               |
| /Medical<br>Examiner   | failure. List only one cause on eac<br>Immediate Cause (Final disease a. C | contact Gunshot Woul                                | nd of Head                      |  |  |                                      | Death   |
| _Xaiiiiiei   | or condition resulting in death)   | ue to (or as a consequence o                        | of):                            |  |  |                                      |   |
| 9  |  | ue to (or as a consequence o                        | of):                            |  |  |                                      |   |
| red nisit Examine  | cause. Enter Underlying Cause (Disease or injury that initiated            | ue to (or as a consequence o                        | of):                            |  |  |                                      |   |
| n and Chansit  | events resulting in death) Last L<br>d.                                    | de to (or as a consequence t                        |                                 |  |  |                                      |   |
| = s s s  | UNPENDED   | AMENDED   |                                 |  |  |                                      |   |
| Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be ex rs after death.  31 Director: After this certificate has been signed by the attending physician led in by the funeral director, page 2 should be detached for use as the burial ertification: To Be Completed by Physician/Medic  | IF FEMALE:<br>23b. Was decedent pregnant in the                            | 23c. If yes, outcome of preg                        |                                 | 0  |  | 23d. Date of delivery                |   |
| certification of the certifica | past 12 months?  | 1 Live birth 4 Pregnant at time of de               | 2 Fetal death eath 5 Other (Spe |  | gnancy                                       | Month D                              | ay Year   |
| BOS<br>e death<br>the att<br>ed for  | 1 Yes 2 No 9 Unknown   | 9 Unknown   |                                 |  |  |                                      |   |
| Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the att completely filled in by the funeral director, page 2 should be detached for ledical Certification: To Be Completed by Physi  | Part II. Other significant conditions                                      | contributing to death but not                       | resulting in the underlyin      | g cause given in Part I.                             |  | 2 ✓ No 3 Prob                        |   |
| fs, F<br>quires<br>en sign<br>uld be   |  |   |                                 |  |  | Delia del Como                       | topsy findings available                                |
| Records, The law requirer ficate has been signage 2 should be Completed  |  |   |                                 |  | autopsy performe                             | ed? death?                           | ompletion of cause of                                   |
| Re if The Cor  | 25. Was case referred to medical   |   |                                 | 26.Place of Death (Che                               | 1 Yes 2                                      | No 1 ✓ Ye                            | s 2 No  |
| /ital  |  | ospital: 1 Inpatient 2                              | ER/Outpatient 3                 | Ious -   |  | esidence 6 Other                     | :   |
| of Ving Physical distribution of To  | 27. Manner of Death  | 28a. Date of Injury<br>(Month, Day, Year)<br>FOUND: | 28b. Time of Injury             | 28c. Injury at Work?                                 | 28d. Describe how<br>Subject shot s          |                                      |   |
| Division o spital or Attending nours after death. neral Director: After filled in by the function:   | 1 Natural 5 Pending 2 Accident Investigation                               | Apr 20, 2012  | FOUND:<br>0832 hrs              | 1 Yes 2 🗸 No   |  |                                      |   |
| Jivis<br>I or A<br>after<br>d in by  | 3 Suicide 6 Could not be determined  |   |                                 | y, office building, etc.                             | or Town, Stat                                |                                      | ral Route Number, City                                  |
|  | 4 Homicide 29a, Certifier  | (Specify) residence<br>n: To the best of my knowled |                                 | e time date and place.                               |  |                                      |   |
| Division of Vital Division of Vital To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certificantlely filled in by the funeral director.  Medical Certification: To Be   | (Check only one) 2 Medical Examiner:                                       | On the basis of examination and manner stated.      | and/or investigation, in m      | y opinion, death occurre                             | ed at the time, date an                      | d place, and due to the              | e cause(s)  |
|  | 29b. Signature and title of certifier                                      | and marrier stated.                                 | 29                              | c. License number                                    | 2  | 29d. Date signed (Moi                | nth, Day, Year)   |
| /3   | 1////  | 1   | Ma                              | O.C.M.E.   | /  | April 21, 2012                       |   |
|  | 30. Name and address stresson who c  |   |                                 | Itimore Street Pa                                    | timore MD 2122                               | 23                                   |   |
|  |  | Assistant Medical Exam                              |                                 | Itimore Street, Ba                                   | LINIOIE, IVID 2 122                          | . <del>.</del>                       |   |
| State<br>Registrar   | MER 0.3 ///  | 2 Lenson  | ture faces                      | · · · · · · · · · · · · · · · · · · ·                |  | (V' + +                              |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 04-Remeikis 09 - 2012S. 11:30 PM Peggy Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Centreville Queen Corsica Hills Nursing & Rehab. Annes Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 - M 2X F 90 220-12-1937 08-12-1921 Md. **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location with the Maryland notified at 10d. Inside City Limits Director Md. Queen Annes Centreville 1 ¥ Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō ıral", or items 23a or I Examiner must be ı Funeral 21617-2125 205 Armstrong U.S.A. hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Specify: White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than " College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. Own Home Homemaker 10 Be Page 1 and 2 should be filed in ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Carrie M. Sinclair item 27 is marked other traumatic e John L. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6635 Reese's Pride Road, Sherwood, Md. 21665 Anthony J. Remeikis, Jr., / Son 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date 04 - 12 - 2012Salisbury Crematory Salisbury, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Physical Red Ostrowski Funeral Home C. F. S.P. Joseph Ostrowski 71. P.O. Box 518 St. Michaels, Md. 21663 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph<sub>a</sub>si∟ian Adult Failure to Thrive disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Years Alzheimers Dementia Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy jo Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 g 🗌 Unknown the cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 □ No 3 □ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA X Nursing Home 5 Residence 6 Other (Specify) upleted filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident within 24 hours after deatl

To the Funeral Director:
completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 ☐ Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifig

Registrar

3

NS

State

32. Registrar's Signature

610 Dutchmans Lane, Easton, Md. 21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. Crowley, M.D.

APR 1 3 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:06 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 17333 Blossom View Drive Olney Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Min. **Director** 071-26-3399 1 M 2 X F 80 01/01/1932 VA Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Olney 1 X Yes 2 No 10e. Street and Number r items 23a or iner must be n ō 10f. Zip Code 10g. Citizen of What Country? Funeral 17333 Blossom View Drive 20832 USA and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) er than "natural", or iter the Medical Examiner 14. Race - American Indian. Armed Forces?

1 Yes 2X No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Corrections Officer New York State Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Josephine Tucker traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Darzell Paz/daughter 17700 Eaglesham Place, Olney, MD 20832 Department of Healt Important: If item 2 any injury or other once. injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Heaven Cem. 04/27/2012 Silver Spring, MD Gate Ineral Service Licerue 21. Signature Snowden Funeral Home 22. Name and Address of Facility 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to or as a conse uence of Examir Jiclan L. s burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Other (specify) Day Year g 🗌 Unknown g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has autopsy performed? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) n 24 hours after death.

ne Funeral Director: After the pletely filled in by the funera 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 3 U Suiciae 4 U Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check ithin 2 the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 4/23/2012

Registrar

DHMH 17 Rev 06-2011

State

Geoffrey Coleman, 1355 Piccard Drive, Suite 100, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

APR 24 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Phyllis Muriel Starr 1:15 P.M April 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Potomac Manor Care Potomac Montgomery 8. Date of Birth

(Month, Day, Year)

April 16,1918 Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Min. 1 M 2 F New York 085-03-8223 Director 94 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sh notified a MD Rockville Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? must be Funeral 23a 11801 Rockville Pike #602 20852 United States ral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Bace - American Indian. Armed Forces Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after oment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 Specify: White If Yes, Give 1 Yes 2 X No Specify. 3 Widowed 4 Divorced Year or Dates ntal Hygiene. ced other than "natura sevent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Clerical 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alexander Z. Cohen Bertha Solomon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill Starr/Daughter 5721 Mayfair Manor Dr., Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 16 Department of H Important: If ite any injury or oth once. Geo. Wash. University Medical Center 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 ▼ Donation 5 ☐ Other (Specify) 2012 22. Name and Address of Facility Columbia Mortuary Services, P.A. Signature of Funeral Service Licer /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph\_sician/ Chronic Renal Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Atherosclerotic Vascular Disease Sequentially list conditions, many, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on ng physician and e as the burialyrapsit Exami or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 the attending IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 🛣 No jo Dav Pregnant at time of death 1 Yes 2 X 9 Unknown detached 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Congestive Heart Failure 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Atrial 24a. Was an s certificate has blirector, page 2 s autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 💢 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death s after death.

I Director: After the din by the funeral 28b. Time of Certificate: 28c. Injury at work? 1X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined within 24 hours a

To the Funeral C

completed filled Hospital Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

29b. Signature and title of certifier

homas Mas

Thomas Masterson, M.D.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

croon

0

29c. License number

D50534

6858 Old Dominion Dr. #104

McLean, VA 22101

29d. Date signed (Month, Day, Year)

April 17, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 8:14 AM <u>Apri</u> 2012 <u>Vivian G. Smith Searles</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Saint Thomas More Nursing Home Prince George's Hyattsville 8. Date of Birth (Month, Day, Year) August 30,1 Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕱 F Months Hours Days Director 578-44-5449 930 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland notified at 10d. Inside City Limits Director 28a-f 1 X Yes 2 No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 1218 Longfellow Street, North West 20011 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black "natural" 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Health Care Nurses Assistant permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Smith Dorothy Kelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1218 Longfellow Street, North West Washington, District of Columbia 2001 Gwendolyn V. Wright/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Arlington National April24,2012 <u>Arlington, Virginia</u> 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, North West Washington, District of Columbia 20012 Signature of Funeral Service License Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Hiberosduplie ardiovascular disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of). attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Demenna 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of Hypertenno 24a. Was an has autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagn 2 No Yes 2 N 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 181 2012 006 36 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1835 Kurup, ,M.D. University Blvd-E; Hyattsville. MD 20783 State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| 2012 140 | 20 | 12 | 14 | 5 | 6 |
|----------|----|----|----|---|---|
|----------|----|----|----|---|---|

|   |                | 1- For State<br>Registrar   |  | Certific           | cate of D                       | eath                       |  |   | eg. No.  | 12 1700   |
|---|----------------|---|--|--------------------|---------------------------------|----------------------------|--|---|--|---|
| Physici<br>Medical Exami  |                | 1. Decedent's Name (First, Midd<br>Seraf:   | in Perez   | Sa                 |                                 |                            | 2. Date of Dea<br>Month<br>April 30, 2 | Day Year  | 3. Time of Death<br>0814 hrs                         |   |
|   |                | 4a. Facility Name (if not institution  Johns Hopkins Bayvio   |  |                    |                                 | City, Town, or<br>altimore | Location of De                         | eath  | 4c. County of Di                                     | eath  |
| Funeral<br>Director   |                | 5. Social Security Number   | 6. Sex 7. Ag   | e (In yrs. last bi |                                 | Under 1 Year<br>Nonths Day |  | Via.  | /1985  | Birthplace (State or reign CourMexiCO                     |
| w any   |                | Usual Residence of Decedent  10a. State  10b. County  |  | 10c. City, Tow     |                                 |                            |  |   | · · · · · · · · · · · · · · · · · · ·                | 10d. Inside City Limits                                   |
| yland<br>P-f sho  | tor            | MD  10e. Street and Number  |  | Ба                 | ltimor                          | f. Zip Code                |  |   | 0- 02  | 1 X Yes 2 No  |
| eath with the Maryland<br>items 23a or 28a-f show<br>ust be notified at once.   | al Director    | 101 N.Janne   |  |                    |                                 | 2122                       |  |   | Og. Citizen of What C                                | 0   |
| P 5 B   | by Funeral     | 11. Marital Status 1   ↑ Never Married 2 M 3 Widowed 4 Div  | arried 12. Was Decedent Armed Forces? 1 Yes 2 Forced If Yes, Give Year or Dates: |                    | 13. Was De<br>If Yes, s         | pecify Cubar               | n, Mexican, Pu                         | ( Specify Yes or No<br>erto Rican, etc.)<br>Kican | 14. Race - Ar<br>White, etc                          | nerican Indian, Black,<br>c.<br>White                     |
| 2 hours   | eted t         | <ol> <li>Decedent's Education (Spe<br/>Elementary/Secondary (0-12)</li> </ol>                         | cify only highest grade com<br>College (1-4 or 5                                 |                    | Decedent's U<br>during most o   |                            | tion (Give kind<br>. DO NOT use        |   | 16b. Kind of Busine                                  | ss/Industry   |
| 0036<br>within 7<br>jene.<br>ner than   | Completed      | 3   |  |                    | Sa                              | les                        | ·                                      |   | Flor   | al  |
| 215- <br>be filed<br>ontal Hyg<br>urked ott   | Be             | 17. Father's Name (First, Middle<br>Angel Perez   | Figueroa   |                    |                                 |                            | Ire                                    | ne (First, Middle, I<br>ne Sant                   | os Gil   |   |
| Dre, MD 21215-0036 ss I and 2 should be filed within 72 hours after of Health and Mental Hygiene. If item 27 is marked other than "natural", her traumatic event, the Medical Examiner. | ٩              | 19a. Informant's Name/Relations Araceli Meno  |  |                    |                                 |                            |  |   | nber, City or Town, St<br>ltimore,                   | Md 21224  |
| Baltimore,<br>ocmit. Pages I an<br>Department of Heal<br>important: If iten   |                | 20a. Method of Disposition  1 XBurial 2 Cremation  4 Donation 5 Other S                               | pecify: /  |                    | of Disposition atory or other p | Cemet<br>Cas               | tery 5                                 | Date / 8 / 2 0 1 2                                | 20c Location - City<br>El Viej<br>pec de<br>rez, Pue | or Town State<br>O Tlacote-<br>Benito Jua-<br>bla, Mexico |
| Balt<br>permit.<br>Depart<br>Import<br>injury   | Ш              | 21. Signatur uneral Service   | ) with   | -                  | <sup>23</sup> 中<br>9241         | and Address<br>Colu        | KINAL<br>imbia                         | DI FUNE<br>Blvd.Si                                | RAL SERV<br>lver Spr                                 | ICE,P.A<br>ing,Må20910                                    |
| Physician<br>/Medical   |                | 23a, Part I. En or the dispase, or failure. List only one cause                                       | on each line.  |                    |                                 | 5 A T 1 T 1                | such as cardia                         | c or respiratory arre                             | est, shock, or heart                                 | Approximate Interval<br>Between Onset and                 |
| Examiner  |                | Immediate Cause (Final disease or condition resulting in death)                                       | a. Acute Alco  Due to (or as a conse   |                    | ion                             |                            |  |   | Death  |   |
| 1   | je             | Sequentially list conditions, if any, leading to immediate  | b. Due to (or as a conse   | quence of);        |                                 |                            |  |   |  |   |
| Bit G &   | edical Examine | cause. Enter Underlying Cause<br>(Disease or injury that initiated<br>events resulting in death) Last | C. Due to (or as a conse   | quence of):        |                                 |                            |  |   |  |   |
| 760, icate be executed physician and the burial - transit   | dical          | X UNPENDED  | d AMENDED 23a  | ,27,28             | a-f,per                         | me,g9                      | 27 5-1                                 | 8-12 sm   |  |   |
| cate Dhy  | ΣI             | IF FEMALE:<br>23b. Was decedent pregnant in the past 12 months?                                       | 23c. If yes, outcom  1 Live birth  4 Pregnant at t                               |                    | 2 Fetal de<br>5 Other (         |                            | Ectopic pre                            | gnancy  | 23d. Date of deliv<br>Month                          | ery<br>Day Year   |
| P.O. E res that the d   | <u>a</u>       | Part II. Other significant condit   | ions contributing to death   | but not resultin   | ng in the under                 | ying cause g               | iven in Part I.                        |   |  | to the cause of death?                                    |
| cords law requi   | Completed      |   |  |                    |                                 |                            |  | 24a. Was a autop: perfor                          | sy prior t<br>med? death                             |   |
| Vital Rec<br>ysician: The<br>his certificate<br>director, page  | Bec            | 25. Was case referred to medical examiner?  |  |                    |                                 |                            | of Death (Che                          | ck only one)                                      |  |   |
| Physic rathis   | 잂              | 1 ✓ Yes 2 No  | Hospital: 1 Inpatier   |                    |                                 |                            |  | sing Home 5                                       |  | ner;  |
| on of anding Ph   | ion            | 27. Manner of Death  1 Natural 5 Pend   | 28a. Date of Injur<br>(Month, Day,Ye   | ar)                | Time of Injury                  | 4                          | y at Work?<br>es 2 🗙 No                | unknown   | low injury occurred                                  |   |
| Divisior pital or Attend ours after death teral Director: filled in by the  | Certification: | 3 Suicide 6 X Could   | tigation 28e. Place of Injuned (Specify) Fou                                     | ury - At home, fa  |                                 |                            | uilding, etc.                          | 28f. Location (S                                  | treet and Number or tate) 101 N. J                   | Rural Route Number, City anney St.                        |
| To the Hospi<br>within 24 hour<br>To the Funer  | edicai C       | 29a. Certifier 1 Certifying Pr  | nysician: To the best of my<br>niner:On the basis of exam<br>and manner stated.  |                    |                                 |                            |  | nd due to the cause                               | e(s) and manner as st                                |   |
| 300   | ž<br>W         | 29b. Signature and title of certifie  |  |                    |                                 | 29c. License               |  |   | 29d. Date signed (M                                  | fonth, Day, Year)   |
| J-1-6   |                | mic   |  | 2                  |                                 | O.C.N                      | И.Е.<br>                               |   | May 1, 2012  |   |
|   |                |   | nt Medical Examiner  | ,                  | Baltimore St                    | reet, Balti                | more, MD 2                             | 21223   |  |   |
| Sta<br>Registi  | ite<br>ar      | 31. Date filed (Month, Day, Year)   | 012 Registrar  | s Signatire        | parke                           |                            |  |   |  |   |

DHMH 17 Rev 7/2009

State Registrar racie

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

688-C

DO

Registrar's Signatur

G

ber

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>M</sup>04/17/2012 Gary Lee Simas 11:40 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 20141 Point Lookout Road #8 Great Mills St. Mary's 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min (Month, Day, Year) 215-54-8332 **Director** 58 1**XX**M 2 □ F 09/08/1953 Usual Residence of Decedent Washington, DC 28a-f show filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Maryland | St. Mary's Great Mills 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral USA 20141 Point Lookout Rd. 20634 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Medical Examiner Armed Force Black, White, etc. P by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2xx No Specify: "natural", 3 Widowed 4XXDivorced Specify: Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) Il Hygiene. Carpenter Construction 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental F is marked o ပ Victor R. Simas permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. Rena Picone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheril Simas / Step-Mother 6902 Nashville Rd. Lanham, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place, Kalas Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 🔭 Cremation 3 🗌 Removal from State Edgewater, Maryland 4/19/2012 4 Dona 5 Other (Specify) Funeral Service Licensee <sup>22. Name and Address of Facility</sup>George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 Signatu 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause a aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, n ach line. r complications Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ LARDIO RESPIRATORY ARREST disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death the Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Degenerative Arthritis Completed 1 Yes 2 No 3 x Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an Schizophrenia has page 2 autopsy perfor certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) xaminer? 1 No. 2 No. Hospita nours after death.

neral Director: After this continued in by the funeral dire Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home XX Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XX Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

within 24 hours a

To the Funeral E

completely filled

State

Medical

29a. Certifier (Check

only one

3

29b. Signature and title of certifier

Youngsik Moon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

1 XXertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D09178

29d. Date signed (Month, Day, Year)

04/18/2012

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14564 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death Anne Arundel Mandrin Hospice House Harwood If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. (Month, Day, Year) Director 102-42-0729 1 M 2 XX 62 3/1/1950 NY 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Crofton MD Anne Arundel 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21114 1667 Forest Hill Ct. USA be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

XX Yes 2 \( \text{No } 1968-\) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 XXIo Specify: 3 Widowed 4 Divorced If Yes, Give Year or Dates Specify Completed 1969 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Delivery Driver Fed Express Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be: Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ewoonce. မ Lawrence Holt Mae Ellerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christal Shrader 5901 Montrose RD. AC401 N. Bethesda, MD 20852 daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/20/2012 Atlantic Crematory Glen Burnie, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, Md 21401 10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) signed by the atte d be detached for Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an Was a. autopsy performed? certificate has 2 🗌 No 1 Yes To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) Ce 6 Other Specify Hospital: 2 No Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Tyes 2 No Accident M Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) gnature and title of death (Item 23a) (Type, Print)

State

Registrar

3

|  |                  | For   | lease                        |   |  |   |                                      |                           |                                      |            | <b>III Copie</b><br>Iental Hy                            |                        | Legible                           | Э.         |                                       |
|--|------------------|---|------------------------------|---|--|---|--------------------------------------|---------------------------|--------------------------------------|------------|--|------------------------|-----------------------------------|------------|---------------------------------------|
|  | -                | State     Registrar   |                              |   |  |   | rtificat                             |                           |                                      |            |  | Reg. No.               | 201                               | 2          | 14565                                 |
| Physicia<br>Medic  |                  | 1. Decedent's Name (First, Manager)  Joan Febbo   | Sol                          | is  |  |   |                                      |                           |                                      |            | 2. Date of De<br>April                                   |                        | 201Ž <sup>ear</sup>               |            | Time of Death  1:25 a  M              |
| Examin   | er               | 4a. Facility Name (if not instituted Montgomery 1   | , 0                          |   | . ,  | e.  | 4b. City                             |                           | Location o                           |            |  | 4c. (                  | County of De<br>Mont              |            | rv                                    |
| Funeral  |                  | 5. Social Security Number   | 6. Sex                       |   | 7. Age (In yrs.                            |   | If Unde<br>Months                    | r 1 Year<br>Days          | If Under<br>Hours                    |            | 8. Date of Bir<br>(Month, Da                             | th<br>v Yearl          | 9. E                              |            | State or Foreign                      |
| Director   |                  | 172-26-8251 Usual Residence of Deced  |                              | ] м 2 🔼 👍   | 79   | Yrs.  | , months                             | Sayo                      | 110010                               |            | June 4   |                        |                                   | PA         |                                       |
| yland<br>f shov<br>ed at   | tor              | 10a. State 10b. Co  | ounty                        |   | 10c. C                                     | ity, Town or Lo                             | cation                               |                           |                                      |            |  |                        |                                   | 10d. l     | nside City Limits                     |
| or 28a-<br>notifia   | Direc            | MD<br>10e. Street and Number  | Mor                          | tgome   | ry   | Burt  | onsví                                |                           |                                      |            |  | 10- 04                 |                                   | Д          | 1 🗌 Yes 2 🔀 No                        |
| with the s 23a c ust be  | Funeral Director | 3923 Dunes  | Way                          |   |  |   |                                      | 0866                      |                                      |            | 1  | USA                    | zen of What (                     | Jountry?   |                                       |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifited at once.  | by               | 11. Marital Status 1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☑ Div  | Married                      | 12. Was Dece<br>Armed Fo<br>1  Yes<br>If Yes, Giv<br>Year or Da | 2 🔀 No<br>'e                               |   | Was Deced<br>If Yes, speci<br>1  Yes | cify Cubar                | spanic Ori<br>n, Mexicar<br>Specify: | n, Puerto  | cify Yes or No-<br>Rican, etc.)                          |                        | 14. Race - An<br>Black, Wh<br>Whi | ite, etc.  | ndian,                                |
| nin 72 hour<br>ne.<br>ihan "natul<br>e Medical   | Completed        | 15. De<br>(Specify only<br>Elementary/Secondary (0  |                              | cation  |  | life. D                                     | kind of wo                           | rk done d<br>e retired)   | uring mos                            |            | 3  | 16b. Kir               | nd of Busines                     | s/Industr  | у                                     |
| ed with<br>Hygier<br>other I   | BeC              | 17. Father's Name (First, Mid   | Idle, Last)                  |   |  | Human                                       | Reso                                 | urce                      |                                      |            | St<br>e (First, Middle,                                  |                        | leral (                           | Gover      | nment                                 |
| d be fill  | 2                | Anthony Febbo   | . ,                          |   |  |   |                                      |                           |                                      | a Del      |  |                        | umame)                            |            |                                       |
| nd 2 shoul<br>salth and 1<br>n 27 is ma<br>er trauma   |                  | 19a. Informant's Name/Rela  |                              |   | n  |   |                                      |                           |                                      |            | Route Numbe  |                        |                                   |            | )                                     |
| Page 1 ar<br>ment of He<br>ant: If iter<br>ury or oth  |                  | 20a. Method of Disposition 1 🖾 Burial 2 □ Crem 4 □ Donation 5 □ Ot  |                              | Removal from  | State                                      | Place of Dispo<br>cemetery, cred<br>Lvary C | natory or o                          | other place               | e)                                   | Apr.       | il 19<br>12  |                        | cation - City                     |            | State                                 |
| permit. Depart Import any inj  |                  | 21. Signature of Funeral Ser  | vice License                 | , 0   | `  | Fž  | alicel                               | d Addres                  |                                      |            | Funeral  |                        |                                   |            |                                       |
|  |                  | 23a. Part 1. Inter the disea  | se, or compli                | cations that  | caused the dea                             |   |                                      |                           |                                      |            |  |                        | r Spri                            | -          | MD 20901<br>proximate                 |
| Physician/<br>Medical<br>Examiner  |                  | shock, of heart failure.<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)           | enst only one                | Metas   |  | Adenoca<br>quence of):                      | rcino                                | ma o                      | f Un                                 | knowi      | n Prima  | ry                     |                                   |            | erval Between<br>set and Death        |
|  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Į                            | Due to  | (or as a consec                            | quence of):                                 |                                      |                           |                                      |            |  |                        |                                   |            |                                       |
| s be executed sician and e buria-transit   | cal              | that initiated events<br>resulting in death) Last   |                              |   | (or as a consec                            | quence of):                                 |                                      |                           |                                      |            |  |                        |                                   |            |                                       |
| rtificate<br>ing phy<br>e as th  | /Med             | IF FEMALE:  |                              |   |  |   |                                      |                           |                                      |            |  |                        |                                   |            |                                       |
| To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the I   | Physician/Medi   | 23b. Was decedent pregnant in the past 12 months?  1  |                              |   |  |   |                                      |                           |                                      |            | 2  | 3d. Date of d<br>Month | elivery<br>Day                    | Year       |                                       |
| uires that t<br>n signed b<br>uld be deta  | by               | Part II. Other significant co   | nditions con                 | tributing to d  | eath but not re                            | esulting in the I                           | underlying                           | cause give                | en in Part                           | l.         |  |                        |                                   |            | use of death?                         |
| The law req<br>ate has bee<br>page 2 sho   | Completed        |   |                              |   |  |   |                                      |                           |                                      |            | 24a. Was<br>auto<br>perfo                                | osy<br>ormed?          | prior to<br>death?                | complet    | indings available<br>tion of cause of |
| ician:   | Be               | 25. Was case referred to me examiner?   |                              | ospital:  |  |   |                                      |                           | ice of Dea                           | th (Check  |  | Z ESFINO               | Hosp                              |            |                                       |
| Phys<br>er this c<br>eral dir  | e: <u>1</u> 0    | 1 ☐ Yes 2 ☒ No<br>27. Manner of Death   |                              | 1   |  | 28b. Time o                                 |                                      | Othe<br>28c. Injury       | 4 ∟ Ni                               |            | me 5 Resid   |                        | Other (Spe                        | ecify)     |                                       |
| ending<br>eath.<br>or: Afte<br>the fun   | ficat            | 2 Accident Ir   | ending<br>vestigation        | (Mon:   | th, Day, Year)                             | injury                                      | М                                    | work?                     |                                      |            |  | ,,                     |                                   |            |                                       |
| ital or Att<br>ins after d<br>al Direct<br>led in by   | al Certificate:  |   | could not be etermined       |   | of Injury - At h<br>ng, etc. <i>(Speci</i> |   | eet, facton                          | y, office                 |                                      |            | 28f. Location (\$<br>City or Tow                         |                        | Number or R                       | ural Rout  | te Number,                            |
| the Hospi<br>hin 24 hou<br>the Funer<br>mpletely fil   | Medical          | (Check 2   Med<br>only one) 3 Cert  | ical Examine<br>ifying Nurse | er: On the bas  | sis of examination                         | on and/or inves                             | tigation, in<br>, death occ          | my opinior<br>urred at th | n, death oo<br>ne time, da           | courred at | nd due to the ca<br>the time, date a<br>ce, and due to t | ind place, a           | and due to the                    | e cause(s) | and manner stated                     |
| Note that the second se |                  | 29b. Signature and title of ce  | _                            | 1. Ther   | ) rel                                      | INP   | 290                                  | : License<br>R1           | number<br>L 2069                     | 8          |  |                        | il 13,                            |            | ,                                     |
|  |                  | 30. Name and address of pe  |                              |   | ,  |   |                                      | card                      | Driv                                 | e. R       | ockvill  | e. Mi                  | D 2085                            | 0          |                                       |
| Stat<br>Registra   |                  | 31. Date filed (Month, Day, Y   | ear)                         | 32 R  | egistrar's Sign                            |   |                                      |                           | - L L V                              | -, A       | CULVIII  | C, FII                 | 2003                              | <u> </u>   |                                       |
|  |                  |   |                              |   |  |   |                                      |                           |                                      |            |  |                        |                                   |            |                                       |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|   |  |                  | For   | State of   | Maryland                                |                                      |   | Health and   | Mental Hy                       | giene                             | 112               | 11.500  |  |
|---|--|------------------|---|--|---|--------------------------------------|---|--|---------------------------------|-----------------------------------|-------------------|---|--|
|   |  |                  | State Registrar  1. Decedent's Name (First, Middle,   | l ast)   |   | Cer                                  | tificate of   | Death  | 2. Date of Dea                  |                                   | )   2             |   |  |
|   | Physicia<br>Medic  |                  | 7. Decedent's Name (First, Middle,  | •  | nne SHOR                                | !E                                   |   |  |                                 | 13, Day 2012                      | Year Year         | 3. Time of Death<br>11:36 Рм                                |  |
|   | Examin   |                  | 4a. Facility Name (if not institution, 11420 Strand Dr  |  | per)                                    |                                      | 4b. City, Town, c   | or Location of Death                                 | n                               | 4c. County                        | of Death          | ry  |  |
|   | Funeral<br>Director  |                  | 5. Social Security Number  550-54-4398  Usual Residence of Decedent   | 6. Sex<br>1 □ M 2 🂢 F  | 7. Age (In yrs. last                    | t birthday)<br>Yrs.                  | If Under 1 Year<br>Months Days                            |  | (Month, Day                     | y, Year)                          | Counti            | ace (State or Foreign<br>y)<br>hoslovakia                   |  |
| aryland   | a-f show<br>fied at  | ector            | 10a. State 10b. County  | gomery   |   | Town or Loc<br>Rockvi                |   | <u></u>  | 1 -                             |                                   | 10                | 0d. Inside City Limits 1 ☐ Yes 2 💢 No                       |  |
| the Ma  | a or 28<br>be noti   | Funeral Director | 10e, Street and Number  |  |   |                                      | 10f. Zip Code   |  | T                               | 10g. Citizen of V                 |                   | ry?   |  |
| ath wit   | ems 23   | uner             | 11420 Strand Dr   |  | lent Ever in U.S.                       | 13 V                                 | 208   | 352<br>Hispanic Origin? (S <sub>l</sub>              | pecify Yes or No-               | United                            | Stat<br>- America |   |  |
| land 21215-0036<br>be filed within 72 hours after death with the Maryland | nd Mental Hygiene.<br>marked other than "natural", or items 23a or 28a-f show<br>matic event, the Medical Examiner must be notified at   | Completed by F   | 1 ☐ Never Married 2 🂢 Marri<br>3 ☐ Widowed 4 ☐ Divorced   | Armed Ford   | ces?<br>2 <b>X</b> No                   | lf If                                | Yes, specify Cub  | an, Mexican, Puert                                   | o Rican, etc.)                  | Black, White, etc. Specify: white |                   |   |  |
| 15-0  | "natu<br>ledical   | nplet            | 15. Deceden<br>(Specify only highes   | t's Education<br>et grade completed)                                 |   | (Give h                              | ent's Usual Occu<br>ind of work done<br>O NOT use retired | during most of wor                                   | rking                           | 16b. Kind of Bu                   | ısiness/Ind       | ustry   |  |
| 212<br>within   | giene.<br>Ier thar<br>t, the N   |                  | Elementary/Secondary (0-12)   | College (1-4   | 1 or 5+)                                |                                      | Estate  | <sup>′</sup> _                                       |                                 | Real                              | Estat             | e   |  |
| <b>Maryland 21215-0036</b><br>2 should be filed within 72 hours after     | dental Hy<br>arked oth<br>itic event   | To Be            | 17. Father's Name ( <i>First, Middle, La</i><br><b>Henryk</b>   | <sup>sst)</sup><br>Ernest St   | adler                                   |                                      |   |  | ne (First, Middle,<br>1y Sidon  |                                   | )                 |   |  |
| <b>S</b> 28   | th ar  | 8                | 19a. Informant's Name/Relationsh<br>Moris Shore, Hu   | 1 1 21 1 2   | 1                                       | 19b. Mailin<br>11420                 | g Address (Street<br>) <b>Strand</b>                      | and Number or Ru<br>Drive #1                         | 79 Route Numbe<br>06, Rock      | r, City pr Town, S<br>VIIIe,      | MD Zip 2          | 0852  |  |
| Baltimore,<br>permit. Page 1 and  |  |                  | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other Si                               | 3 ☐ Removal from Specify)  |   | ce of Dispo<br>netery, crem<br>Lebar | sition (Name of<br>natory or other pla<br>non Ceme 1      | tery 04/   | Date<br>16/12                   | 20c. Location -<br>Ade1p          | -                 | 1   |  |
| Balti<br>permit.  | Department Important: I any injury or once.  |                  |   | centee   | 5                                       | 76                                   | rchthsky<br>4 Carro                                       | γ°Mēb⊬ew<br>11 StN                                   | Funeral<br>W. Washi             | Home                              | DC 2              | 0012  |  |
| - 1   | veicials   |                  | 23a. Part 1. Enter the disease, or shock, or heart failure. List or Immediate Cause (Final                  | nly one cause on eac   | h line.                                 | Do not ente                          |   |  |                                 | _                                 |                   | Approximate<br>Interval Between<br>Onset and Death<br>YEARS |  |
| 1   | Medical<br>xaminer   |                  | disease or condition resulting in death)  |  | y Cancer<br>or as a consequer           |                                      |   |  |                                 |                                   | -                 | 100/3   |  |
|   | ===  | iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (c   | гава сопвадиы                           | ibe of j                             |   |  |                                 |                                   | 75                |   |  |
| <b>U</b><br>be executed   | an and<br>irial (Time  | dical Examiner   | Cause (Disease or injury<br>that initiated events<br>resulting in death) Last                               | c. Due to (c   | r as a consequer                        | nce of):                             |   |  |                                 |                                   |                   |   |  |
| /60<br>cate be  | physici<br>s the bu  |                  |   | d  |   |                                      |   |  |                                 |                                   |                   |   |  |
| <b>Box 68/6</b> death certificate   | been signed by the attending physician and should be detached for use as the burial transi   | Physician/Me     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                     | 1 Live B   | ant at time of dea                      | death 3                              | Ectopic pregnan Other (specify)                           | ncy  |                                 | 23d. Dat<br>Mo                    | e of delive       | y<br>Day Year   |  |
| ords, P.O.  | igned by t<br>be detach  | by               | Part II. Other significant condition  | ns contributing to de  | ath but not result                      | ting in the u                        | nderlying cause g   | iven in Part I.                                      |                                 |                                   |                   | e cause of death?   |  |
| <b>ords</b><br>w requir   | s been s   | Completed        |   |  |   |                                      |   |  | 24a. Was                        | an 24b. V                         | Vere autop        | sy findings available                                       |  |
| Vital Records,<br>sysician; The law requires                              | icate has<br>r, page 2 s   |                  |   |  |   |                                      |   |  | 1 🗆 Yes                         | rmed?                             | death?            | pletion of cause of   |  |
| <b>Vital</b><br>ysician   | is certifi<br>directo  | To Be            | 25. Was case referred to medical examiner?  1  Yes 2 No   | Hospital:  | npatient 2  E                           | R/Outpatien                          | - LOtt  | Place of Death (Che<br>her:<br>4 \(\sum \) Nursing F | ck only one)                    | dence 6 🗆 Othe                    | er (Specify)      |   |  |
| n of  | h.<br>After thi<br>funeral   | :ate:            | 27. Manner of Death 1 XNatural 5 ☐ Pending  | 28a. Date o  |   | 8b. Time of injury                   | 28c. Inju<br>wor  | ry at  | T                               | ow injury occurre                 |                   |   |  |
| DIVISION OF<br>tal or Attending Pt  | after deat<br><b>Director:</b><br>I in by the  | Certificate:     | 2 Accident Investig 3 Suicide 6 Could r 4 Homicide determi  | ot be 28e. Place of  | of Injury - At hom<br>g, etc. (Specify) | e, farm, stre                        | eet, factory, office                                      |  | 28f. Location (S<br>City or Tow | Street and Numbern, State)        | er or Rural I     | Route Number,   |  |
| Hospital  | within 24 hours after death.  To the Funeral Director: After this certificate I per the Funeral Director, After this certificate I per the funeral director, page to make the funeral director, page the funeral director and the funeral director and | ledical          | (Check 2 Medical Ex   | Physician: To the be<br>caminer: On the basis<br>Nurse Practitioner: | s of examination a                      | and/or invest                        | igation, in my opin                                       | ion, death occurred                                  | at the time, date a             | nd place, and due                 | to the caus       | se(s) and manner stated.                                    |  |
| To the  | within within 200 the comp   | Σ                | 29b. Signature and title of certifier   | C. P. J.   | - L                                     | 1 D                                  | 29c. Licens   |  |                                 | 29d. Date signed April 1          | (Month, D         | ay, Year)   |  |
|   |  |                  | 30. Name and address of person w  | rho completed cause  | of death (Item 2                        | 3a) (Type, P                         | rint)<br>Road, NW   | I, Washin  | gton, DC                        | 20007                             |                   |   |  |
|   | Stat<br>Registra   |                  | 31. Date filed (Month, Day, Year)  APR 16 20  | _82_Re   | gistrar's Signatur                      |                                      |   |  |                                 |                                   |                   |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First\_Middle\_Last) 2. Date of Death Physician/ April 2012 11:13 ам Mary E. Stover Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Silver Spring Holy Cross Hospital Social Security Numbe If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 1 🗆 M 2 🎗 F 84 (Month Pay / 1927 **Director** 180-20-2547 Pennsylvania "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring Maryland Montgomeru 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20901 228 Whitmoor Terrace U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 X Married Completed by Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates 1 and 2 should be filed within 72 hours of Health and Mental Hygiene.
Item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Company Payroll Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Venus Hummel Mary Blieler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 228 Whitmoor Terrace, Silver Spring, MD 20901 Donald E. Stover - Spouse 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place, 04/23/2012 Fleetwood, Pennsylvania Pauls Union Cem. 4 Donation 5 Other (Specify) 21. Signature of mane a Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Physician/ Interstitial Fibrosis disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): g physician and as the burial transit requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death 2 X No the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Kidney Disease 1 Yes 2 No 3 X Probably 4 Unknown page 2 should Hupertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 🗓 No ည 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at or Attending 1 X Natural 5 Pending М 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined the Hospital 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 2 1725947 APRIL 20, 2012 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3416 Olandwood Court, Suite 200, Olney, Maryland 20832 M.D., Evelyn D. Jackson, 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ Seibolt 2012 Edward J. 3:48 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 15310 Pine Orchard Drive, Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours Min. (Month, Day, Year) Director 024-12-1794 1 M 2 □ F 89 Yrs. Jan. 29, 1923 be filed within remembers the state by the substance of t 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD Montgomery Silver Spring 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 15310 Pine Orchard Drive, 20906 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 ☑ Yes 2 ☐ No Black, White, etc. ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1943-44 1 Yes 2 No Specify. Specify: White 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Government Printing Office Photo Engraver Be permit. Page 1 and 2 should be filed Department of Health and Mentel Hy Important: If Item 27 is merked oth any lijury, or other treumettc event ang. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Edward J. Seibolt Kathleen O'Connell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine S. Fletcher/Daughter 2101 Lubar Court, Brookeville, MD 20833 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 24 X Cremation 3 ☐ Removal from State Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 00 University Blvd. W., Silver Spring, MD 20901 23a. Part 1/6 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Hypertensive Cardiovascular Disease vears Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): that the death certificate be executed Due to (or as a consequence of): resulting in death) Last ettending physician I for use es the buria Medical Box 68760 IF FEMALE: Physician/ yes, outcome of pregna*n*cy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day ☐ Yes 2 ☐ No ed by the e g 
Unknown 9 Unknown P.0. To the Hospital or Attending Priyacus..., within 24 hours after death.

Jothe Funerel Director: After this certificate has been signed to the Funerel Director. After this certificate has been signed to the funeral director, page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 X No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 🛭 Residence 6 Cher (Specify) ည 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending within 24 hours after death.

To the Funerel Director: After completely filled in by the fu 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) om du mo D24543 April 20, 2012

State Registrar

James A. Rossi, MD 3305 N. Leisure World Blvd., Silver Spring, MD 20906 31. Date filed (Month, Day, Year) 32 Registrar's Signature APR 23

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ . 2012 Year April Bradford Stege 20. 10:00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Asbury Solomons Health Care Center Calvert Solomons If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 6. Sex 8 Date of Birth 9. Birthplace (State or Foreign 1 8 M 2 □ F New Jersey 0472771924 **Director** 147-14-2703 87 Usual Residence of Decedent ms 23a or 28a-f sho must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 th No Maryland Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11450 Asbury Circle, Unit 430 20688 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Mever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. em 27 is marked other than the Mertraumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Mail Carrier US Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Elizabeth Weiss / Executor 11450 Asbury Circle, Unit 223, Solomons, MD 20688 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, 1 Burial 2 To Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 04/23/2012 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home. P.A. P.O. Box 600, Lusby, MD 20657 -a1 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause op/ach l he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine as a consequence of and Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Year Pregnant at time of death Day 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant/conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed' Yes 2 No 1 \sum Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Hospital or Attending Pl 24 hours after death. Funeral Director: After th 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number April 23, 2012 D47153 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric Berg, MD 110 Hospital Road, Suite 310, Prince Frederick, MD 20678 10+ 31. Date filed (Month, Day, Year) 32. Registra State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . <sup>Day</sup> 2012 Physician/ April 10m 17 9:47 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Health Care Waldorf Charles 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, OCt . 29 Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign <sup>Year</sup> 19<u>34</u> 1 🕅 M 2 □ F Months Days Hours 198-28-8964 Pennsylvania Director Yrs Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10h County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George Forestville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2512 Lakehurst Ave. 20747 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 2 🔀 No Baltimore, Maryland 21215-0036 ☐ Yes If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify. Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Callege (1-4 or 5+) permit. Page 1 and 2 should be filed withi.
Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatics. 12 Furniture Maker Furniture Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Sciler, Jr. Helen May Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bunny L. Sciler Daughter 4655 Strauss Ave., Indisan Head, Md. 20640 20a. Method of Disposition 20b. Place of Disposition (Name of voice of Disposition (Name of cemetery, crematory or other place) April 19, Metropolitan Funeral Service 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 2. Name and Address of Facility
Williams Funeral Home, 21. Signature of Funeral Service License M00668 4270 Hawthorne Rd., Indian Head, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Disease Immediate Cause (Final disease or condition monic sidne Onset and Death nysician/ Medical resulting in death) Due to (or as a consequence of) Examiner emia oes 149 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the a Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 . 24 hours after deatn. e Funeral Director: After this certificate المعتمد filled in by the funeral director, pag 2 No Yes 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No ုဝ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 18 viation Bludste B, Glen Bushie, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print D8. J05) N V9 2hc-Philly, 6954 F

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ MARYANNE H. STINSON APRIL 13 3:15 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 31529 MILLER ROAD CORDOVA TALBOT If Under 1 Year If Under 24 Hrs. Social Security Numbe **Funeral** Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Min **Director** 208-18-2116 1 M 2 X F 85 Yrs 12/8/1926 PENNSYLVANIA Usual Residence of Decedent or 28a-f shov the Maryland 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director TALBOT 1 Yes 2X No **CORDOVA** 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 31529 MILLER ROAD 21625 USA permit. Page 1 and 2 should be filed within 72 hours after death vipperation of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Specify: WHITE Completed Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12 5+ TEACHER SECONDARY SCHOOL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JOHN WILLIAM HURLEY KATHERINE MURPHY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AUBREY A. STINSON, SON 31521 MILLER ROAD, CORDOVA, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GREENMOUNT CEMETERY HILLSBORO, MARYLAND 4/19/2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, H
200 SOUTH HARRISON STREET, EASTON, MD 21601 JOHN R. MERLERO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physici n >hd Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): the attending physician Physician/Medical death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) Month Day Year No Yes 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ Division of Vital Records, ardio Myopothy Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death.

Funeral Director: After this certificate has autopsy hronic 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be 1 ☐ Yes 2 ☐ No the Accident Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F the only one) 29b. Signature and title 29d. Date signed (Month. Day, Year)

TLS

Month, Day, Year)
APR 1 6 2012 31. Date filed (Month State Registrar

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Heril 13, 2012

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  |                  | State of Maryland / De  | epartment of Health<br>Certificate of Death  |   | 2111   | 2 14572                                      |
|--|------------------|---|--|---|--|--|
| Physicia   | n/               | 1. Decedent's Name (First, Middle, Last)  | ertificate of Death  | 2. Date of Dea<br>Month                                     |  | 3. Time of Death                             |
| Medic<br>Examin  | al               | DOROTHY D. SHERWOOD  4a. Facility Name (if not institution, give street and number)   | 4b. City, Town, or Location  | APRIL   | Day Year 14, 2012 4c. County of Dea              | 3:02 A M                                     |
|  | •                | MEMORIAL HOSPITAL AT EASTON   | EASTON   |   | TALBO  | Γ  |
| Funeral<br>Director  |                  | 5. Social Security Number   6. Sex   7. Age (In yrs. last birthdom)   1 □ M 2 🗓 F   86   Yrs  | Months Days Hours  | 8. Date of Birth (Month, Day)                               | Year) Co   | rthplace (State or Foreign ountry)           |
| and<br>show<br>I at  | or               | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or  | Location   | 10/23/  | 1923   | MARYLAND  10d. Inside City Limits            |
| e Maryl<br>r 28a-f<br>notifiec   | Jirect           | MD TALBOT EASTON  10e. Street and Number  | Lor St. O. I   |   |  | 1 🏋 Yes 2 □ No                               |
| Ind 21215-0036  filed within 72 hours after death with the Maryland tal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at  | Funeral Director | 507 DECATUR PLACE   | 10f. Zip Code 21601  |   | 10g. Citizen of What C<br>USA                    | ountry?                                      |
| or item  | by Fur           | 11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☒ No                           | Was Decedent of Hispanic Ori-<br>If Yes, specify Cuban, Mexicar                        |   | 14. Race - Am<br>Black, Whi                      |  |
| OO3( ours after tural", al Exar  |                  | 3 ☐ Widowed 4 🕅 Divorced If Yes, Give Year or Dates.  | 1 ☐ Yes 2 🕅 No Specify:  |   | Specify: WH                                      | ITE  |
| 215-<br>lin 72 ho<br>e.<br>han "na<br>Medio  | Completed        | (Specify only highest grade completed) (G   | cedent's Usual Occupation<br>ive kind of work done during mos<br>. DO NOT use retired) | t of working  | 16b. Kind of Business                            | :/Industry                                   |
| nd 212<br>filed within<br>al Hygiene.<br>d other than  | Be C             | 12 0 SEC  | RETARY 18. Moth  | er's Name (First, Middle, I                                 | TALBOT CO  | UNTY   |
| faryland<br>should be file<br>n and Mental I<br>is marked o<br>raumatic eve  | 오                | HOWARD WILLIAM SHERWOOD   |  | RTHA GERTRUD  | · · · · · · · · · · · · · · · · · · ·            |  |
|  | 10               | MOTETE E COMMOTENT DATIONS  | ailing Address (Street and Number ELWOOD AVENUE,                                       |   |  | ip Code)                                     |
| imore, lead 2 Page 1 and 2 ment of Healt and 2 ant: If item 2 ury or other   |                  | 1 🔀 Burial 2 □ Cremation 3 □ Removal from State   cemetery, o   | sposition (Name of<br>crematory or other place)  | Date  | 20c. Location - City o                           |  |
| Baltimol permit, Page 1 Department of Important: If is any injury or of  | ¥                | 21. Signature of Funeral Service Licensee   | HILL CEMETERY 22. Name and Address of Facilit  | tv  | EASTON, MA                                       |  |
| <b>m</b> adeso   |                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not  | FELLOWS HELFEN 200 SOUTH HARRI   |   |  |  |
| -Physician/  |                  | shock, or heart failure. List only one cause on each line.  |  | i i   |  | Approximate Interval Between Onset and Death |
| Medical Examiner   |                  | resulting in death)  a. Due to (or as a consequence of):  | clopsel  |   | 3  | da-  |
| т <del>і</del> й   | niner            | cause. Enter Underlying   | Copper S   |   |  | Corys  |
| be executed<br>sician and<br>burial-transit  | Examiner         | Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):                               |  |   |  |  |
| Certificate be conding physicial   | edical           | d   |  |   |  |  |
| Ital Records, P.O. Box 68/60 sician: The law requires that the death certificate be ex certificate has been signed by the attending physician irector, page 2 should be detached for use as the buria  | Physician/Me     | IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death             | 3 ☐ Ectopic prechancy  |   | 23d. Date of de                                  | elivery                                      |
| <b>Box</b> ne death c the atten ched for u   | ysici            |   | 5 Other (specify)  |   | Month  | Day Year                                     |
| s that the gned by the be detach   |                  | Part II. Other significant conditions contributing to death but not resulting in the  | e underlying cause given in Part   |   | bacco use contribute t                           |  |
| ords require been s should   | leted            | chrone obstratie ulman  | y oreise   | 1   |  | Probably 4 Unknown                           |
| Kec  | Completed by     |   |  | autops<br>perfor<br>1 \(\sum \) Yes                         | sy prior to<br>med? death?                       | completion of cause of                       |
| VItal /sician: s certific  | To Be            | 25. Was case referred to medical examiner?  1  Yes 2 No  Hospital:  1  Inpatient 2  ER/Outpa  | Other  | th (Check only one)   |  | -16.)  |
| Ing Phy<br>Ing Phy<br>After thi<br>funeral   |                  | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) injury injury  | e of 28c. Injury at work?  | 28d. Describe ho  | ow injury occurred                               | sity)  |
| DIVISION OF VITAI RECORDS, lal or Attending Physician: The law requires rs after death.  In Director, After this certificate has been signed in by the funeral director, page 2 should be in by the funeral director, page 2 should be in by the funeral director.   | Certificate:     | 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)         | M 1 Yes 2 Street, factory, office  | 28f. Location (St   | reet and Number or Ru                            | ıral Route Number,                           |
| Spital or cours aft or cours aft or cours aft or cours aft or cours or filled in cours or cou | ledical C        | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea   | th occurred at the time, date and  | City or Town  |  | tated  |
| Division of Vital Records,  To the Hospital or Attending Physician: The law requires within 24 hours after death.  To the Funeral Director, After this certificate has been sign completely filled in by the funeral director, page 2 should be  | Medi             | (Check 2 ☐ Medical Examîner: On the basis of examination and/or in only one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowled | vestigation, in my opinion, death od<br>lge, death occurred at the time, da            | ccurred at the time, date an<br>te and place, and due to th | d place, and due to the<br>e cause(s) and manner | cause(s) and manner stated.<br>as stated.    |
| 7 viii   |                  | 29b. Signature and title of certifier  7. Aurle My  | 29c. License number  | 13  | 29d. Date signed (Mont                           | 1, 2012                                      |
| 6  |                  | 30. Name and address of person who completed cause of death (Item 23a) (Typ   | - / /  | An St. E  | ASTON K  | 4) 2/601                                     |
| Stat<br>Registra   | -                | 31. Date filed (Month, Day, Year) 33 Registrar's Signature  | South Voshy  | 1.0   |  |  |
| riegistra  | 1                | APR 1 6 2012 Centra B. pa   |  |   |  |  |

12-02708 Richard Lee Tau

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 14573

|   | 1- For State Cert  | ificate of Death   | Reg. No.   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|
| Physician/<br>ledical Examine   | Decedent's Name (First, Middle, Last)  |  | 2. Date of Death  Month Day Year  April 5, 2012  | 3. Time of Death<br>1820 hrs                                   |  |  |  |  |  |  |  |  |
|   | 4a. Facility Name (if not institution, give street and number) Frederick Memorial Hospital   | 4b. City, Town, or Location of Deat<br>Frederick   | h 4c. Count, of Dea<br>Frederick   | ith  |  |  |  |  |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number 6. Sex 7. Age (In yrs. las 216–04–2975 1 M 2 F 43  | st birthday)   | 1000 Fore  | irthplace (State or<br>eign Maryland<br>country)               |  |  |  |  |  |  |  |  |
| nd<br>show any<br>ice.  | Maryland Frederick   | Town or Location Thurn   | The second secon | 10d. Inside City Limits 1 Yes 2 No                             |  |  |  |  |  |  |  |  |
| th the Maryland 23a or 28a-f show cotified at once. al Director   | 10e. Street and Number<br>6814 Putman Road   | 10f. Zip Code 21788  | 10g. Citizen of What Co<br>USA   |  |  |  |  |  |  |  |  |  |
| more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene.  tot: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be softlind at nace To be Completed by Funeral Director   | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced or Dates:  | If Yes, specify Cuban, Mexican, Puerl  | o Rican, etc.) White, etc.  Specify: White   |  |  |  |  |  |  |  |  |  |
| 11215-0036 Id be filed within 72 hours Aental Hygiene. narked other than "natur event, the Medical Exam De Be Completed 1   |  | 16a. Decedent's Usual Occupation (Give kind of<br>during most of working life. DO NOT use re<br>Master Electrician             | tired) Electri   |  |  |  |  |  |  |  |  |  |
| ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica To Be Comple  |  | Susa   | ne (First, Middle, Maiden Surname)<br>an Higgs   |  |  |  |  |  |  |  |  |  |
| MD 21. ad 2 should the lith and Mer m 27 is man aumatic even  | 19a. Informant's Name/Relationship (Type, Print)  Kaitlyn Leigh Tau, daughter  | 19b. Mailing Address (Street and Number or 19811 Filbert Dr, Ga  | ithersburg, MD 208   | 79   |  |  |  |  |  |  |  |  |
|   | 20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  All Faiths Crematory 4/9/2012 Manchester   |  |  |  |  |  |  |  |  |  |  |  |
| Balti permit. Departu Importu injury  | 21 Signature of Funeral Service Licensee  22. Name and Address of Facility Myers—Durboraw Funeral 210 W Main St, Emmitsburg, MD 21727  |  |  |  |  |  |  |  |  |  |  |  |
| Physician<br>Medical<br>Examiner  | 23a. Flart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line.  Immediate Cause (Final disease a. Carbon Monoxide Intoxication |  |  |  |  |  |  |  |  |  |  |  |
|   | or condition resulting in death)  Due to (or as a consequence of)  Sequentially list conditions,  b.   |  |  |  |  |  |  |  |  |  |  |  |
| t<br>Insit<br>Examiner  | if any, leading to immediate  Character Inderlyin Cause (Disease or injury that initiated Character resulting in death). Leat  |  |  |  |  |  |  |  |  |  |  |  |
| ecuted and - transit  |  |  |  |  |  |  |  |  |  |  |  |  |
| ). Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit Physician/Medical Ex  |  | f yes, outcome of pregnancy  Live birth  2 Fetal death 3 Ectopic pregnancy  Month  Pregnant at time of death 5 Other (Specify) |  |  |  |  |  |  |  |  |  |  |
| , P.O. B res that the d signed by the be detached?  |  | sulting in the underlying cause given in Part I.   | 23e. Did tobacco use contribute  1  Yes 2  No 3 Pi   | robably 4 Unknown  |  |  |  |  |  |  |  |  |
| Division of Vital Records, P.O. Box 687 To the Hospital or Atteoding Physician: The law requires that the death certific within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the land in a formulated by Physician. |  |  | autopsy prior to death'  1 Yes 2 ✓ No 1  | autopsy findings available o completion of cause of ? Yes 2 No |  |  |  |  |  |  |  |  |
| Vital Rec<br>ysician: The<br>his certificate<br>director, page  | 25. Was case referred to medical examiner?   | 26.Place of Death (Chec ER/Outpatient 3 DOA Other Nurs   | k only one) sing Home 5 Residence 6 Ott  | her:   |  |  |  |  |  |  |  |  |
| ing Physi  After this funeral di  | 1 Yes 2 No 28a Date of Injury  | 28b. Time of Injury  FOUND:  1 Yes 2 ✓ No  | 28d. Describe how injury occurred Subject inhaled lawn mower   |  |  |  |  |  |  |  |  |  |
| Division o  Spital or Atteoding tours after death. oeral Director: After filled in by the fune  | Pending  Accident Suicide  Suicide  Natural 5 Pending Investigation  Apr 5, 2012  28e. Place of Injury - At ho determined (Specify) Garage   | 1730 hrs  ome, farm, street, factory, office building, etc.  | 28f. Location (Street and Number or<br>or Town, State)<br>6814 Putman Road, Thurmont, N  |  |  |  |  |  |  |  |  |  |
| To the Hospita Within 24 hours To the Fuceral completely fille  |  | ge, death occurred at the time, date and place, a  | nd due to the cause(s) and manner as s   | tated.   |  |  |  |  |  |  |  |  |
| To the He within 24 To the Fu Complete!   | 29b. Signature and title of certifier  | 29c. License number O.C.M.E.   | 29d. Date signed (#<br>April 6, 2012   | Month, Day, Year)  |  |  |  |  |  |  |  |  |
| 8 Arm   | 30. Name and address of person who completed cause of death (Item Ling Li, MD Assistant Medical Examiner 900 N   | <sup>23a)</sup><br>W. Baltimore Street, Baltimore, MD 2  | 21223  |  |  |  |  |  |  |  |  |  |
| Stat<br>Registra  | tate 31. Date filed (Month, Day, Year) 32. Registrar's Signature,  |  |  |  |  |  |  |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day Physician/ Diane Lynn Trice Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HICOMIOS YENINSULA REGIONAL 546156419 MODICAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min **Director** 219-56-8513 1 M 2 X F 58 oct. 22, 1953 Maryland Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Salisbury Wicomico 1 🗌 Yes 2 💢 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 21804 31004 Nassawango Church Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give White 1 ☐ Yes 2 🙀 No Specify: Specify 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Cato Oil Company Elementary/Secondary (0-12) College (1-4 or 5+) Price Book Coordinator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Agnes Gunning Douglas Charles Earl Dukes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19945 21399 Lowe's Crossing Rd., Frankford, DE 19a. Informant's Name/Relationship (Type, Print) Sherrie L. Trice Upton/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 

 XBurial
 2 □ Cremation
 3 □ Removal from State

 □ Donation
 5 □ Other (Specify)

 05/01/12 Federalsburg, MD Hillcrest Cemetery 22. Name and Address of Facility Framptom Funeral Home, Federalsburg, MD 21632 21. Signature of Funeral Service Licenses 216 N. Main St., Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Won Small disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions ner Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran Due to (or as a consequence of) resulting in death) Last attending physician a I for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 E FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Year Month Day the Unknown 9 Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 DM0 Impatient 2 ER/Outpatient 3 DOA within 24 hours after deau.

To the Funeral Director: After this ( 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work atural 5 Pending 1 Yes 2 No 2 Accider
3 Suicide Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medied Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 34 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

State Registrar R. M.C

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 14575 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April Peter Thrasher 2012 0140 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours **Director** 213-46-3755 1 🗶 M 2 🗆 F 88 Yrs 11/29/1923 Canada Usual Residence of Decede i show or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Kensington 1 Tes 2 X No 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 20895 U.S.A. 4004 Denfeld Avenue 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces?

Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify 3 Widowed 4 Divorced Specify: Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Electronic Equipment life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) n and Mental Hygien 7 is marked other t Leading Radar Technician Repair Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) 2 Nellie Elizabeth Mills John M. Thrasher other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 15 Gemini Avenue, Winnipeg, R2G0T5, Canada Randy E. Hull - Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory 04/24/2012 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simple Tribute Funeral & Cremation 21. Signature of Funeral Service Licensee Center, 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Aspiration Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Failure to Thrive Sequentially list conditions. Dure to (or as a consequence of, cause. Enter Underlying that the death certificate be executed Dementia Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). burialphysician s the burial Physician/Medical Lung Mass Division of Vital Records, P.O. Box 68760 as attending p IF FEMALE s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) Month 1 Yes 2 9 Unknown ed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has autopsy ie Hospital or Attending Physician: The In 24 hours after death.
ie Funeral Director: After this certificate holetely filled in by the funeral director, page performed' 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗶 No ဂ္ 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 🔀 Natural 5 Pending work? Accident Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one) 29b. Signature and titl 29d. Date signed (Month, Day, Year) 20056063 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Kanwaljit Nagi,

31. Date filed (Month, Day, Year) APR 2 3 2012

M.D.

DHMH 17 Rev 06-2011

1500 Forest Glen Road, Silver Spring, Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ April 18, 5:20 AM <sup>M</sup> Joseph Thompson Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 8100 Blossom Point Road We I come Charles 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months (Month, Day, Year) **Director** 75 215-38-6768 1 X M 2 🗆 F June 26,1936 Maryland but be filed within 72 nours are in Mental Hygiene.
In Mental Hygiene.
In marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other than Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 √ Yes 2 □ No Charles Welcome 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8100 Blossom Point Road 20693 **United States** 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed American Indian Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <u> Mail Carrier</u> <u>Postal</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental He filed of Health and Mental He fitem 27 is marked ot Thompson Joseph P. Thompson Edna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Kay Thompson (Wife) P.O. Box 281 Port Tobacco, MD. 20677 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 g Department of I Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Ignatius Cemetery 4/23/2012 Port Tobacco, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Road Waldorf, MD. 20601 Malla 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death avicel Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that the death certificate be executed the burial-trans Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 tobably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tyes 2 X No မ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 2 Accident 5 Pending work? ours after death.

leral Director: Aft
filled in by the fur 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 0 0 31. Date filed (Month istrar's Signature

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04 Day 08 Physician/ 1305 Medical Facility Name (if not institution, give street and County of Death City, Town, or Location of Deat **Examiner** altimore omitua If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Min Director 215-14-1807 1 □ M 2 🕱 F 89 MD 6/3/1922 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland must be notified at Director 1 Yes 2 No Carroll Hampstead MD 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral 21074 USA 2929 Coon Club Road items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ö þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: white "natural" Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) book bindery book binder traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Catherine Barnhart Royer M. Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2929 Coon Club Road, Hampstead, MD 21074 it of Health If item 27 Virginia A. Stoner, sister Baltimore, injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 4/12/2012 1 ☑**X**Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) Meadow Branch Cemeterty 22. Name and Address of Facility M01072 Eline Funeral Home 934 S. Main St., Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ ra disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death A PROVED ! . Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 No Month Day Year Pregnant at time of death signed by the at d be detached for CERTIFICA Unknown 23e. Did tobacco use contribute to the cause of death? δ 2 No Records, 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 this certificate Division of Vital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 24 hours after death. Funeral Director: After 1 Natural Accident 5 Pending Investigation work? 1 ☐ Yes 2 🔀 Vo fall-from 03.30.12 6 Could not be 28e. Place of Injury - At home, farm, building, etc. (Specify) 28f. Location (Street and Number or Rural Route Num street, factory, office 4 Homicide City or Town, State)
2929 Coon Club Rd. Hampshee determined at home Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. WD, 21074 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and many Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 04.08.12 death (Item 23a) (Type, Print) 30. Name and address of person who completed cause

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ William Joseph Vaughan, Jr. April 13, 11:05 p M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Carroll Westminster Carroll Hospital Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 216-48-0317 64 3/2/1948 Director 1 M 2 D F NC or 28a-f show notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Westminster Carroll 1 🗆 Yes 2 😿 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? items 23a or ner must be n USA 21158 5200 Geeting Road death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, an "natural", or iter Medical Examiner Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 🗌 Yes 2 🔀 No If Yes, Give Year or Dates white 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry J Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) A.A.I. - Textron the manufacturing engineer permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygle Important: If item 27 is marked other any injury or other traumatic event, the 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elva Dennis William Joseph Vaughan, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5200 Geeting Road, Westminster, MD 21158 Bonnie S. Vaughan, wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🛣 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4/18/2012 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) Hampstead Cemetery M01072 21. Signature of Funeral Service License 22. Name and Address of Facility Eline Funeral Home 934 S. Main St., Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MOXIC der disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 2day 5 everce if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the i 1 Yes 2 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobagco use contribute to the cause of death? 2 0 TO ENO CALCIAVONIA Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hospital or Attending Physician: The law ate has bage 2 s autopsy performed? Yes 2 certificate 1 Yes 2 No Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ျှ 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral c 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. e Funeral Director: Ai bletely filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) D31660 DIACIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOUASK. LOPS THIN STELL MALY land 2 (157 295 STONER Avenue

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

Darks

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April <sup>Day</sup> 2012 Jeffrey Charles Verbeten 1:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Solomons Nursing Center Calvert Solomons Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 ₩ M 2 □ F (Month, Day, Year) 01/21/195 Wisconsin Director 60 <u>392-56-2333</u> Usual Residence of Deceden 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Funeral Director 28a-f 1 Yes 2 1 No Maryland Calvert Port\_Republic 10e. Street and Number 10g. Citizen of What Country? must be 23a United States 4185 Hance Road 20676 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 A Married Baltimore, Maryland 21215-0036 "natural", 1 Yes 2 No Specify: 3 Divorced 4 Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Communications Analyst U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Charles Verbeten Hilda Naas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Elizabeth Verbeten / Wife 4185 Hance Road, Port Republic, MD 20676 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔛 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or injury or 4 Donation 5 Other (Specify) 04/23/2012 Alexandria, Virginia Metropolitan Crematory Rausch Funeral Home, P.A. Signature of Funeral Service Lice see Hard P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ Scienosis Multiple disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to hours after death.

Funeral Director; After this certificate has been signed by the attending physicis Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed Dementia. 1 Yes 2 No 3 Probably 4 Dunknown After this certificate has been si funeral director, page 2 should I 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? Yes 2 No 1 Yes 2 No the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 X Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sunono D50653 April 23, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Gyan Chand Surana,
31, Date filed (Month, Day, Year)

5851 Deale Churchton Road, Suite 16, Deale, Maryland 20751

Records,

Division of Vital

|   | State of Maryland / Department of Health and Mental Hygiene 2012 1458 |   |   |  |                                |   |                         |                             |                   |                                   |             |   |                                       |       |  |  |  |
|---|---|---|---|--|--------------------------------|---|-------------------------|-----------------------------|-------------------|-----------------------------------|-------------|---|---------------------------------------|-------|--|--|--|
|   |   | State<br>Registrar  |   |  | Cer                            | tificate                                | of De                   | eath                        |                   | F                                 | leg. No.    | 201                                     | C 140                                 | U     |  |  |  |
| Physicia<br>Medic   |   | Decedent's Name (First, Middle C  | , Last)<br>atharine   | Amy Wei  | S                              |   |                         |                             |                   | 2. Date of Dear<br>Month<br>April | Day<br>21   | 2 0 1 2                                 | 3. Time of Death                      | М     |  |  |  |
| Examin  |   | 4a. Facility Name (if not institution,  | give street and num   | ber)   |                                | 4b. City, To                            | wn, or Lo               | ocation of D                |                   | , 1,0.000                         |             | ounty of Death                          | 1.1                                   |       |  |  |  |
|   |   | Asbury Met  | hodist Vi   | llage  |                                | G                                       | Baith                   | iersbu                      | rg                |                                   |             | Montgome                                |                                       |       |  |  |  |
| Funeral<br>Director   |   | 5. Social Security Number 551 – 54 – 6011   | 6. Sex<br>1 ☐ M 2 🗓 F   | 7. Age (In yrs. Ia<br><b>92</b>                          |                                | If Under 1 Months                       |                         | f Under 24 I<br>Hours M     | Hrs.<br>/lin.     | 8. Date of Birth<br>(Month, Day,  | 1920        | 9. Birth<br>Cour                        | place (State or Foreig<br>ntry) Japan | חן    |  |  |  |
| d<br>low  | _   | Usual Residence of Decedent  10a. State 10b. County   |   | 10c City   | , Town or Loc                  | ation                                   |                         |                             |                   |                                   |             |   | 10d, Inside City Limit                | _     |  |  |  |
| Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at   | Completed by Funeral Director   |   | tgomery   | Toc. City  | , fowir or Loc                 | ation                                   | G                       | aithe                       | rsb               | wra                               |             | ŀ                                       | 1 ☐ Yes 2 🛣 N                         |       |  |  |  |
| the Na or 2   | ١   | 10e. Street and Number  |   |  |                                | 10f. Zip Co                             |                         |                             |                   |                                   | 10g. Citize | itizen of What Country?                 |                                       |       |  |  |  |
| h with  | nera  | 333 Russell   | Avenue, R   | oom 426  |                                |   |                         | 20877                       |                   |                                   |             | и.                                      | S.A.                                  |       |  |  |  |
| r deat<br>or iten<br>iner r   | y Fu  | 11. Marital Status<br>1 ☐ Never Married 2 ☐ Marr  | Armed For   |  |                                | Vas Deceden<br>Yes, specify             | rt of Hispa<br>Cuban, I | anic Origin?<br>Mexican, Ρι | (Speci<br>uerto R | fy Yes or No-<br>ican, etc.)      | 14          | Race - Ameri<br>Black, White,           |                                       |       |  |  |  |
| rs afte<br>ral", c<br>Exam  | q pa  | 3 □ Widowed 4 □ Divorced  | ied 1 ☐ Yes<br>If Yes, Giv<br>Year or Da                          | e  | 1                              | ☐ Yes 2 2                               | X No                    | Specify:                    |                   |                                   | Sp          | pecify:                                 | Caucasian                             |       |  |  |  |
| 2 hour  | plet  | 15. Deceder   | nt's Education<br>st grade completed)                             |  |                                | ent's Usual C                           |                         |                             | working           | ,                                 |             | of Business Ir                          |                                       |       |  |  |  |
| thin 7;   | mo:   | Elementary/Seconday (0-12)  | College (1-   |  |                                | NOT use re<br>Socia                     | etired)                 | •                           |                   | ·                                 |             | Psychia<br>cial Wa                      |                                       |       |  |  |  |
| ed wi<br>Hygie<br>other<br>ent, tl  | Be (  | 17. Father's Name (First, Middle, L   | ast) 5  | <del>*</del>   |                                | 3000                                    |                         |                             | Name              | First Middle N                    |             |   | , cice c                              |       |  |  |  |
| d be fill<br>Mental<br>arked o  | 2   | 17. Father's Name (First, Middle, Last)  Luman J. Shafer  18. Mother's Name (First, Middle, Maiden Surname)  Amy K. Hendricks         |   |  |                                |   |                         |                             |                   |                                   |             |   |                                       |       |  |  |  |
| shoul<br>and<br>is ma   |   | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State) |   |  |                                |   |                         |                             |                   |                                   |             |   |                                       |       |  |  |  |
| and 2<br>Health<br>em 27<br>ther t  |   | Barbara Winifre   | d Weis/Da   |  |                                |   |                         | eet,                        |                   |                                   |             |   | ind 20902                             |       |  |  |  |
| t: Kitch  | _   | 1 🗌 Burlal 2 🛭 Cremation  |   | State C6   | ace of Dispos<br>emetery, crem | atory or othe                           | er place)               |                             | Da                |                                   |             | ation - City or T                       | •                                     |       |  |  |  |
| + + E = .   |   | 4 Donation 5 Other (S   |   |  |                                |   |                         |                             |                   |                                   |             |   | Maryland<br>L & Cremat                | ic    |  |  |  |
| permi<br>Depar<br>Impor<br>any ir   |   | March 7.  | Vefula  | M0124  |                                |   |                         |                             |                   |                                   |             |   | MD 20852                              | ~~    |  |  |  |
| c   |   | 23a. Part 1 Enter the disease, or shock, or heart failure. List o   | nly one cause on ea   | ch line.   |                                |   | of dying, s             | such as card                | diac or           | respiratory arre                  | est,        |   | Approximate<br>Interval Between       |       |  |  |  |
| Physician/  |   | Immediate Cause (Final disease or condition   | a 12  | reus   | 2016                           | in                                      |                         |                             |                   |                                   |             |   | Onset and Death                       | L     |  |  |  |
| Medical Examiner  |   | resulting in death)   | Due to (  | or as a conseque   | ence of):                      |   |                         |                             |                   |                                   |             | 1                                       |                                       |       |  |  |  |
|   | ner   | Sequentially list conditions, if any, leading to immediate  | b. Due to (   | or as a conseque   | ence of):                      |   |                         |                             |                   |                                   |             | _                                       |                                       |       |  |  |  |
| ate be executed obysician and the burial-traceits   | Examiner  | cause. Enter Underlying Cause (Disease or ilinjury that initiated events  |   |  |                                |   |                         |                             |                   | - 3                               |             |   |                                       |       |  |  |  |
| oe exe  | dical E   | resulting in death) Last  | ence of):   |  |                                |   |                         |                             |                   |                                   |             |   |                                       |       |  |  |  |
| cate to   | യ   |   | d   |  |                                |   |                         |                             |                   |                                   |             |   |                                       |       |  |  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Jo the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial. It posts  | Physician/M   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No   | 1 Live  | come of pregnan<br>Birth 2 D Fetal<br>nant at time of de | death 3                        | Ectopic pre                             |                         |                             |                   |                                   | 23          | d. Date of deliv                        | ery<br>Day Year                       |       |  |  |  |
| t the d<br>by the<br>tacher   | Phys  | g 🗌 Unknown   | 9 Unkr  |  |                                |   |                         |                             |                   |                                   |             |   |                                       | _     |  |  |  |
| requires that the de<br>been signed by the s<br>should be detached  |   | Part II. Other significant condition  | ins contributing to di  | eath but not resu<br>Late                                | ilting in the ur               | nderlying cau                           | use given               | iņ Part I.                  |                   | 23e. Did tob                      |             |   | he cause of death?<br>bably 4  Unknow | un    |  |  |  |
| requii<br>been<br>should  | lete  | Knowster  | in an O   | ster   | 1 ths                          | Otto                                    |                         |                             | _                 | 24a. Was a                        |             |   | psy findings available                |       |  |  |  |
| The law<br>ate has<br>page 2  | Completed by  | History H   | ial fibr  | nt isc   | lier                           | ni                                      | at                      | tou                         | 6                 | autops<br>_ perfori               | sv -        |   | impletion of cause of                 |       |  |  |  |
| ian: T  | Be C  | 25. Was case referred medical examiner?   |   |  |                                |   |                         | of Death (C                 | Check c           |                                   | Z EL INO    | i 🗆 ies                                 | 2 🗆 110                               |       |  |  |  |
| hysician:<br>his certific<br>I director,  | To E  | 1 ☐ Yes 2 ☐ No  | Hospital:   | Inpatient 2 🗆 E  | R/Outpatien                    | 3 🗆 DOA                                 | Other:                  | 4 Nursin                    | ng Hom            | e 5 🗌 Reside                      | ence 6      | Other (Specif                           | 1)                                    |       |  |  |  |
| ding Ph<br>h.<br>After th<br>funeral  | Certificate:  | 27. Manuer of Death 1 ☑ Natural 5 ☐ Pendin  | 9   | of injury<br>h, Day, Year)                               | 28b. Time of<br>injury         |   | . Injury at work?       |                             | - 1               | ld. Describe ho                   | w injury o  | ccurred                                 |                                       |       |  |  |  |
| deatl<br>ctor:<br>y the   | rtific  | 2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could r   | not be  | of Injury - At hor                                       | ne. farm. stre                 | M<br>et. factory. of                    |                         | s 2 🗆 No                    | -                 | Rf. Location (St.                 | reet and N  | lumber or Rum                           | l Route Number,                       |       |  |  |  |
| al or /<br>s after<br>il Dire<br>ed in b  |   | 4 ∐ Homicide determi  |   | ng, etc. (Specify)                                       | ,                              | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                         |                             |                   | City or Town                      |             |   | , riedto riamod,                      |       |  |  |  |
| To the Hospital or Attent within 24 hours after death To the Funeral Director. Completed filled in by the   | Medical   | (Check 2 L Medical E  | Physician: To the bas<br>xaminer: On the bas<br>Nurse Practioner: | s of examination   | and/or investi                 | gation, in my                           | opinion,                | death occum                 | red at th         | ne time, date an                  | d place, ar | nd due to the ca                        | use(s) and manner sta                 | ited. |  |  |  |
| To the within To the complete | Σ   | 29b. Signature and title of certifier   |   |  | Kilowiedge, d                  |   | icense nu               |                             | place,            |                                   |             | signed (Month,                          |                                       |       |  |  |  |
| 12  |   | V. Reher  | t Bis   | lika   | Jaca                           | 0                                       |                         | 4115                        |                   | 4                                 | fre         | 123,                                    | 2012                                  |       |  |  |  |
|   |   | 30. Name and address of person v  | who completed caus  |  | 23a) (Type, Pr                 | rint)                                   | 6                       | 201                         | RI                | 18522                             | LAG         | 4 VEIV.                                 | 20847                                 |       |  |  |  |
| Stat  |   | 31. Date filed (Month, Day, Year)  APR 2 4 2  | 2012 37 R   | egistrar's Signat  | re La                          | 2                                       |                         |                             | /                 | 7,000                             | J           | , | /                                     |       |  |  |  |
| Registra  | 1   | AFR ATA   | WIL KEN   | un p   | 17                             |   |                         |                             |                   |                                   |             |   |                                       |       |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State AMEND#23a(a)perMD,4/24/12;bm/w,McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2012 Month April Physician/ 22 12:30pm<sup>M</sup> Chienching Wanghou Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 15 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Year 19<u>23</u> Hours 88 Yrs. China **Director** June 013-88-6261 Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 😾 No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country an "natural", or items 23a or Medical Examiner must be Funeral 21117 Hickory Forest Way 20876 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 X Widowed 4 ☐ Divorced Specify: Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.
is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the 4 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ "Unknown" "Unknown" 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 21117 Hickory Forest Way, Germantown, MD 20876 Kevin Wang (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 
Burial 2 
Cremation 3 
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 4/25/2012 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Funeral Service Licen Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Perfora" Ph\_sician/ -(Non-Trumatic) disease or condition resulting in death) Medical Due to (or as consequence of): Examiner Sequentially list conditions riany, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as -transit en Jion that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2X No 3 Ectopic pregnancy Year Day Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown s been signed by the should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: ပု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man or of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending injury Natural 5 Pending work?
1 Yes 2 No thin 24 hours after death.

the Funeral Director: At mpleted filled in by the fu 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title/of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive Rockville, MD 2085 aghi MD

State Registrar

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

|  |  |  | For State   | State of N  | /larylan                 |                              |  |  |                   | nd Menta                              | I Hygie                 | ene  | 210  | 115                                   | 0 1        |
|--|--|--|---|---|--------------------------|------------------------------|--|--|-------------------|---------------------------------------|-------------------------|--|--|---------------------------------------|------------|
|  | _  |  | Registrar  1. Decedent's Name (First, Middle  | , Last)   |                          | Cer                          | Certificate of Death Reg. No. 202  |  |                   |                                       |                         |  |  |                                       | 8          |
|  | Physicia<br>Medic  |  | Josephine   |   | ade                      |                              |  |  |                   | Mon<br>A pi                           |                         | 9, 20  | $oldsymbol{1}^{	ext{Year}}_{oldsymbol{2}}$ | 3. Time of Dea<br>7:20r               |            |
|  | Examin   |  | 4a. Facility Name (if not institution, Washington Adv   | give street and number)<br>entist Hospit                                      | tal                      |                              | 4b. City, Tow<br>Take  |  | cation of<br>Park |                                       |                         | 4c. County<br>M on   | of Death                                   | ery                                   |            |
|  | Funeral<br>Director  |  | 5. Social Security Number 218-05-9207   | 6. Sex 7. A   | ge (In yrs. Ia           | 1                            |  | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min. |                   |                                       |                         | 8. Date of Birth<br>(Month, Day, Year)                                   |  |                                       | reign      |
|  |  |  | Usual Residence of Decedent   | I LI WI Z LAFT  |                          | Yrs.                         |  |  |                   | 0 ct                                  | . 7,                    | 1917   | Sout                                       | h Caroli                              | na         |
|  | arylanda-f she   | Director   | 10a. State 10b. County M D Montg  | omery   | 10c. City                | , Town or Loc                | sation<br>Silve  | r Sp   | ring              |                                       |                         |  | 1  | 0d. Inside City Li<br>1 🔀 Yes 2 [     |            |
|  | the M<br>a or 28<br>be noti  | I Dir  | 10e. Street and Number 2201 Colstor   | Drive apt   | .#801                    | _                            | 10f. Zip Co  |  | 210               |                                       |                         | g. Citizen of \  |  | try?                                  |            |
|  | ms 23<br>must  | Funeral  |   |   |                          | l                            |  | 209  |                   |                                       |                         | United States  |  |                                       |            |
| 980  | filed within 72 hours after death with the Maryland tal Hygiene. So on the "hatural", or items 23a or 28a-f show event, the Medical Examiner must be notified at                       | by   | 11. Marital Status  1 Never Married 2 Marr 3 X Widowed 4 Divorced                               | ied 12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates.        | ?                        | ) If                         | Yes, specify (   | Cuban, M   | 1exican, F        | n? (Specify Yes o<br>Puerto Rican, et | or No-<br>c.)           | 14. Race - American Indian, Black, White, etc. Specify: African American |  |                                       |            |
| 2-0  | 2 hours<br>"natur<br>edical I  | plete  |   | t's Education<br>st grade completed)  | T                        | 16a. Deced                   | Decedent's Usual Occupation     (Give kind of work done during most of working |  |                   |                                       |                         |  | usiness/Ind                                |                                       |            |
| 121  | ed within 7,<br>Hygiene.<br>other than   | Completed  | Elementary/Secondary (0-12)   | College (1-4 or 5+  | 5+)                      | life. DO                     | O NOT use reti   | ired)  | -                 | Counse                                | 1                       | Educa  | ation                                      |                                       |            |
| During the part of |  |  |   |   |                          |                              |  |  |                   |                                       | liddle, Mai             |  | <del></del>                                |                                       |            |
| Baltimore, Maryland 21215-0036   | sho<br>han<br>7 is<br>trau   |  | 19a. Informant's Name/Relationsh Phyllis Wade Al  | ip (Type, Print)<br>bro / daught  |                          |                              |  |  |                   |                                       |                         | ity or Town, S   | itate, Zip C                               | ode)                                  |            |
| ore,   | ge 1 and 2<br>it of Healt<br>If item 2<br>or other   |  | 20a. Method of Disposition 1 ☐ Burial 2 😾 Cremation   | 3 Removal from Stat   | e ce                     | metery, crem                 | sition (Name o   | place)   |                   | Date                                  |                         | Oc. Location -   |  | wn, State                             |            |
| Itim   | :. Pag<br>tmen<br>tant:<br>jury  |  | 4 Donation 5 Other (S   | pecify)   | Ches                     | _                            | e Crem   |  | ~ :               | /24/2012<br>McGuire                   | ٠                       |  | -  | _                                     |            |
| B  | permit. Departr Imports any inji   |  | Undre' The  | 2008Son   |                          |                              |  |  |                   |                                       |                         |  |  | C 20012                               |            |
|  |  |  | 23a. Part 1. Enter the disease, or<br>shock, or heart failure. List o<br>Immediate Cause (Final | complications that cause<br>nly one cause on each lin                         | ed the death<br>ne.      | . Do not ente                | r the mode of  | dying, su  | uch as ca         | rdiac or respirat                     | ory arrest,             | ,  |  | Approximate<br>Interval Between       |            |
|  | Physician/<br>Medical  |  | disease or condition resulting in death)  | a. Due to (or as  | a conseque               | ence of:                     | 101  | A  | 4                 | KCC                                   | 700                     |  |  | Onset and Deat                        | n          |
|  | Examiner   | J.   | Sequentially list conditions,   | 6 ON  | GE                       | 518V                         | E 1  | 0  | 40                | R De                                  | 32                      | ule  | 25   |                                       |            |
|  | ted ted  | Examiner   | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                   | Due to (or as   | a conseque               | ence of):                    | 7-1  | AT   | . I               | 2A37                                  | 111                     | RE   |  |                                       |            |
|  | icate be executed physician and is the buriated  | al Ex  | that initiated events<br>resulting in death) Last   | Due to (or as   | a conseque               | ence of):                    |  | 10   |                   | - 01                                  | 1118                    | 1/1/12   | 1 1/2                                      | 2 A                                   | _          |
| 760  | cate be<br>physic<br>s the b   | edical   |   | <b>d</b> .(.) + (0)   | 3/10                     | 045                          | 5700   | 1 CZ   | The same          | 2 /11                                 | emo                     | NANY   | 2  | 50° >                                 | <u> </u>   |
| Box 68   | The law requires that the death certificate has been signed by the attending page 2 should be detached for use as  | Physician/M  | IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknewn         | 23c. If yes, outcome 1  Live Birth 4  Pregnant 9  Unknown                     | 2 Fetal<br>at time of de | death 3 🗌                    | Ectopic pregr<br>Other (specify  |  |                   |                                       |                         | 23d. Dat   | te of <b>de</b> live<br>nth                | ry<br>Day Year                        |            |
| P.O.   | that the<br>ned by<br>e detac  | by Ph  | Part II. Other significant condition  | ns contributing to death  | but not resu             | Iting in the ur              | nderlying caus   | e given ir   | n Part I.         | 23e.                                  | Did tobac               | cco use contr  | ibute to the                               | cause of death                        | ?          |
| ds,  | requires<br>been sign<br>should by   |  |   |   |                          |                              |  |  |                   | _                                     | 1 🗌 Yes                 | 2 🗌 No   | 3 🗌 Prob                                   | ably 4 Unkr                           | iown       |
| Division of Vital Records,   | The law re<br>ate has be<br>page 2 sh  | Completed  |   |   |                          | -                            |  |  |                   | _   _                                 | Was an autopsy performe | d?   | Vere autop<br>prior to con<br>leath?       | sy findings availant pletion of cause | able<br>of |
| ital   | sician: The<br>certificate I<br>irector, page  | Be   | 25. Was case referred to medical examiner?  | Hospital:   |                          |                              |  |  | of Death (        | (Check only one                       | -                       |  |  |                                       |            |
| of V   | g Phys<br>er this<br>eral di   | e: To  | 1 ☐ Yes 2 ☐ No<br>27. Manner of Death   | 28a. Date of inj  | ury 2                    | R/Outpatient<br>28b. Time of | 28c. l   | njury at   | ☐ Nursi           | ing Home 5 28d. Desc                  |                         | e 6 Othe   |  |                                       |            |
| ion  | tending<br>leath.<br>or: Aft<br>the fur  | Certificate:   | 1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could n                                     | ation   | ay, Year)                | injury                       |  | vork?  | 2 🗆 No            | o                                     |                         |  |  |                                       |            |
| Divis  | ital or Attars after of ral Direct   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |   |                          |                              |  |  |                   |                                       | or Town, S              | State)   |  | Route Number,                         |            |
|  | To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Medical  | (Check 2 Medical Ended only one) 3 Certifying   | Physician: To the best of caminer: On the basis of Nurse Practitioner: To the | examination :            | and/or investi               | aation, in my o  | pinion, de   | eath occu         | rred at the time.                     | date and r              | place, and due   | to the caus                                | se(s) and manner                      | stated.    |
|  | 20   |  | 29b. Signature and title of certifier   | F N   | 10                       |                              | 290. 100   | ense pun   | nber              | 07                                    | 29d                     | Date signed  | (Month, D                                  | ay, Year)                             |            |
|  |  |  | 30 Name and address of person w   | ho completed cause of   | death (Item 2            | 23a) (Type, Pr               | int)   | 200  | ) (<br>VE         | mit                                   | eze<br>Pi               | And  | IN   | W.Sr                                  | 91         |
|  | Stat   | е  | 31. Date filed (Month, Day, Year)   | 32. Registr   | rar's Sichatu            | re book                      | 1  |  |                   |                                       |                         |  | (  |                                       |            |

|  |                   | Ple  1 _ For State   | ase Type or F<br>State of                              | Print in Bla<br>Maryland /              | Depa                        | rtment of  | Health a                        |               | -                                   |                                  | egible.                      | 2 1458  |
|--|-------------------|--|--|---|-----------------------------|--|---------------------------------|---------------|-------------------------------------|----------------------------------|------------------------------|---|
| Physicia   |                   | Registrar  1. Decedent's Name (First, Midd  ALLONA ELIZA)  | . ,  |   | Cert                        | ificate of   | Death                           |               | 2. Date of Dea<br>Month             | _                                | 201 <sup>Year</sup>          | 3. Time of Death <b>0950</b> M                |
| Medic<br>Examin  |                   | 4a. Facility Name (if not institutio  CHESTER RIVER  | n, give street and number                              | er)<br>ENTER                            |                             |  | TERTOW                          | of Death      | AIKIL                               | 4c. Cou                          | nty of Death                 |   |
| Funeral<br>Director  |                   | 5. Social Security Number  216-40-8275  Usual Residence of Decedent  | 6. Sex 7.  | . Age (In yrs. last b                   |                             | If Under 1 Year<br>Months Days                                   | If Under 2<br>Hours             | Min.          | 8. Date of Birl<br>(Month, Da)      | y, Year)                         | Cou                          | hplace (State or Foreign<br>Intry)            |
| death with the Maryland<br>items 23a or 28a-f show<br>ner must be notified at  | <b>Director</b>   |  | ANNE'S   | 10c. City, To                           | wn or Loca                  | ILLE   |                                 |               |                                     |                                  |                              | 10d. Inside City Limits 1 ☐ Yes 2X No         |
| ath with the Maryla<br>ems 23a or 28a-f s<br>r must be notified  | Funeral Director  | 204 HAYDEN ROA   | AD   | ent Ever in ILS                         | 13 W                        | 10f. Zip Code 21 as Decedent of H                                | 617                             | in? (Speci    | ify Yes or No-                      |                                  | of What Cou                  | ATES  |
| 72 hours after dea<br><br>an "natural", or iter<br>Medical Examiner  | ρ                 | 1 Never Married 2 Ma 3 Widowed 4 Divorce   | Armed Force 1 Yes 2 If Yes, Give Year or Date          | es?<br>2 💢 No                           | lf `                        | Yes, specify Cub   | an, Mexican,                    | , Puerto Ri   | ican, etc.)                         |                                  | Black, White                 | , etc.  |
| vithin 72 ho<br>liene.<br>Ir than "nat<br>the Medica   | Completed         |  | ent's Education<br>nest grade completed)  College (1-4 | or 5+)                                  | (Give kir                   | nt's Usual Occu<br>nd of work done<br>NOT use retired<br>MAKER   | during most                     | of working    | g                                   | 16b. Kind of                     | f Business/I                 | •   |
| 12 should be filed within 72 aith and Mental Hygiene. 27 is marked other than "r traumatic event, the Med  | To Be             | 17. Father's Name (First, Middle, LEONARD HUBBE  | ,  |   |                             |  | 1                               |               | (First, Middle,                     |                                  |                              |   |
| and 2 should<br>Health and M<br>em 27 is mar<br>ther traumati  |                   | 19a. Informant's Name/Relations  THERESA LYNCH  20a. Method of Disposition   |  | 2                                       | 04 H                        | Address (Street  |                                 | ENTRE         | VILLE,                              | MD 21                            | 617                          |   |
| permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra  |                   | 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other ( 21. Signature of Puneral Service   | (Specify)  | tate LAKEM                              | tery crema<br>ONT M<br>DENS | tion (Name of<br>atory or other pla<br>EMORTAL<br>Name and Addre | 0                               |               | /2012                               | DAVIDS                           | •                            | Town, State                                   |
| permi<br>Depar<br>Impor<br>any ir  | _                 | 23a. Part 1. Enter the disease, of   | or complications the Col                               | used the death. Do                      | FEI                         | LLOWS, H   | ELFEN<br>CK RO                  | BEIN<br>AD, C | HESTER                              | MD 2                             | ERAL<br>1619_                | HOME, P.A.  Approximate                       |
| Physician/<br>Medical  |                   | shock, or heart failure. List<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)   | a  | as a consequence                        | ITE<br>a of):               | myo  | redi                            | M             | NEA                                 | ectro.                           | $\sim$                       | Interval Between<br>Onset and Death           |
| ate be executed shysician and the burial-transit   | edical Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | C  | as a consequence                        | yst                         | Any  | MIL                             | ny            | di                                  | TEMS                             | E                            | 15 years                                      |
| To the Hospital or Attending Physician: The law requires that the death certificate be excuithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician are completely filled in by the funeral director, page 2 should be detached for use as the burial completely filled in by the funeral director, page 2 should be detached for use as the burial director. | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  |  | rth 2  Fetal dea<br>nt at time of death |                             | Ectopic pregnan<br>Other (spec <i>ify)</i> _                     | су                              |               |                                     |                                  | Date of deli                 | very<br>Day Year                              |
| luires that t<br>an signed b<br>ald be deta  | ٥                 | Part II. Other significant conditions CONGEST  | IVE hEAR   | t (Ai)                                  |                             |  | ven in Part I.                  |               | 23e. Did to                         |                                  |                              | the cause of death?                           |
| The law rec<br>ate has bee<br>page 2 sho   | Completed         | Atleial<br>SALCOTO   | Abrill A   | H.N                                     |                             |  |                                 |               |                                     |                                  | prior to co<br>death?        | opsy findings available ompletion of cause of |
| ysician:<br>is certific<br>director,   | To Be             | 25. Was case referred to medical examiner? 1 ☐ Yes 2 No  | Hospital:  | patient 2 ER/C                          | Outpatient                  | 26. P  | lace of Deather:                |               | only one)<br>ie 5 🗆 Resid           | lence 6 $\square$ 0              | ther (Specif                 | fv)   |
| tending Ph<br>Jeath.<br>tor: After th<br>the funeral   | Certificate:      | 27. Manner of Death  1 Natural 5 Pendi  Accident Invest  3 Suicide 6 Could   | 28a. Date of (Month, igation                           | injury 28b.<br>Day, Year)               | Time of injury              | 28c. Injur<br>worl<br>M 1  | y at                            | 28            | 3d. Describe h                      |                                  |                              | 3/  |
| spital or At<br>lours after of<br>neral Direct<br>filled in by   |                   |  |  |   |                             |  |                                 |               |                                     | n, State)                        | _                            | al Route Number,                              |
| the Ho   | Medical           | (Check 2 Medical   | Examiner: On the basis g Nurse Practitioner: To        | of examination and                      | or investig                 | ation, in my opini   | on, death occ<br>the time, date | curred at th  | ne time, date a<br>e, and due to ti | nd place, and<br>ne cause(s) and | due to the ca<br>d manner as | ause(s) and manner stated stated.             |
| 5 3 5 3  |                   |  |  |   |                             | 0  | 20560                           | 76            | ,                                   | 29d. Date sigi                   | 1/18                         | 12  |
| State  | e                 | 30 Name and address of person PATLIC A 31. Date filed (Month, Day, Year)   | Bowyer 1   | ND MPH                                  |                             |  | evall.                          | Deve          | E, CEN                              | Merul                            | IE N                         | 10 21617                                      |
| Registra   |                   | APR 19   |  | strar's Signature                       | pa                          | ele  |                                 |               |                                     |                                  |                              |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Rose Evelyn Wheatley 0720 16, 2012 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Caroline Envoy of Denton Denton 8. Date of Birth
(Month, Day, Year)
April 16,1919 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2**X** F Months Hours Maryland 93 221-05-7172 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature". 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Caroline Denton 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21629 420 Colonial Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼No
If Yes, Give
Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Completed by 3€ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Private Caregiver 11 (Grad.) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace Hopkins Moore Gorman Slacum 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20460 Diamond J. Dr., Bridgeville, DE 19933 Emily S. Johnson/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State East New Market, Maryland East New Market Cem. 04/17/12 4 Donation 5 Other (Specify) <sup>22. Name and Address of Facility</sup> Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Mukarl 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** heimer's YEAKS /Medical Due to (or as / consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 1∏ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1/2 Natural Injury I Director: A 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral I To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Doo47534

State Registrar

DHMH 17 Rev 1/2001

920 Market St., Denton, MD 21629

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wafik Zaki, MD

APR 17 2012

31. Date filed (Month, Day, Year)

۵.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 14586 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Judith K. Walters 2012 April 7:36a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Columbia Howard 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) 218-42-7284 **Director** 1 □ M 2 🛣 F 67 Yrs July 16,1944 Maryland 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits with the Maryland Director Ellicott City 1 🗌 Yes 2 🔀 No MD Howard 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Funeral 7612 Stony Creek Lane 21043 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 0 þ 1 Never Married 2 Married Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural" Completed 3 Nidowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accounting Clerk Accounting 12 alth and Mental Hygie
27 is marked other
r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William F. Patten Dolores Ridgell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 1175 Lafayette Drive Eldersburg, MD 21784 Drew Walters/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State April 20, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn, MD 2012 Name and Address of Facility of Funeral Service Funeral Home Rarranco & Sons, 495 Ritchie Hwy. P.A. Sev Severna Earl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between as a Insequence of Onset and Death Immediate Cause (Final Cancer with mets to the liver Ph. sician disease or condition Weeks Medical resulting in death) Due to (or as a **Examiner** Sequentially list conditions, Examiner bus to for es a consequence of/ if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and I for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed' this certificate 2 **N**0 Yes 2 1 Yes 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer injury 1 Natural 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

the Hospital 20

31. Date filed (Mont State

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

0060634

COLUMBIA

29d. Date signed (Month, Day, Year,

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  |              | For  | State of I  | Marylan                        | •  |  |                         | nd Mental Hy                                | giene                   |  | h 1 pm                          | 0 -    |  |
|--|--------------|--|---|--------------------------------|--|--|-------------------------|---|-------------------------|--|---------------------------------|--------|--|
|  |              | State Registrar  |   |                                | Cer  | tificate of L  | Death                   |   | Reg. No.                | <u> 2012</u>                                       | 145                             | 8_1    |  |
| Physicia   |              | 1. Decedent's Name (First, Middle Estelle Ruth                                 | e, Last)<br>Wyatt   |                                |  |  |                         | 2. Date of De<br>Month<br><b>April</b>      | Day                     | 112 Year   | 3. Time of Death 12:25          |        |  |
| Medic<br>Examin  |              | 4a. Facility Name (if not institution  | , give street and number  | r)                             |  | 4b. City, Town, or   | Location of D           |   |                         | nty of Death                                       | 12.25                           |        |  |
| <i>)</i>   |              | Montgomery Hos   | pice-Casey  | House                          | 2  | Rockv  | ille                    |   | Mont                    | tgomery  | 7                               |        |  |
| Funeral  |              | 5. Social Security Number  |   | Age (In yrs. la                | st birthday)                                     | If Under 1 Year<br>Months Days                                 |                         | Hrs. 8. Date of Bir<br>Vin. (Month, Da      | th<br>v, Year)          | 9. Birthp  | place (State or Fore            | ign    |  |
| Director   |              | 251-20-9227 Usual Residence of Decedent  | 1 □ M 2 🏝 F   | 96                             | Yrs.   |  |                         | Sept. 4                                     |                         |  | SC                              |        |  |
| and<br>show<br>at  | ö            | 10a. State 10b. County   |   | 10c. City                      | , Town or Loc                                    | cation   |                         |   |                         | 1  | 0d. Inside City Lim             | iits   |  |
| Aaryla<br>8a-f s<br>tified   | Director     | MD Mont  | gomery  | Roc                            | kville   | 2  |                         |   |                         |  | 1 🛚 Yes 2 🗆                     | No     |  |
| the tage or 2  |              | 10e. Street and Number   |   |                                | 10f. Zip Code                                    |  |                         | 10g. Citizen of What Country?               |                         |  |                                 |        |  |
| n with   | Funeral      | 1214 Gladston  | e Drive   |                                |  | 20851  |                         |   | USA                     |  |                                 |        |  |
| re, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at  | ۵            | 11. Marital Status  1 ☐ Never Married 2 ☐ Mar  3 🌁 Widowed 4 ☐ Divorced        | 101/201   | s?<br>☑No                      |  | Vas Decedent of Hi<br>Yes, specify Cuba                        |                         | ? (Specify Yes or No-<br>uerto Ricaп, etc.) | 14. F<br>E<br>Spec      | Race - Americ<br>Black, White, e<br>White<br>cify: | ato                             |        |  |
| 5-C  | plet         |  | nt's Education<br>est grade completed)  |                                | 16a. Deced                                       | ent's Usual Occupa   | ation<br>Juring most of | workina                                     | 16b. Kind o             | f Business/Ind                                     | dustry                          |        |  |
| H21  | Completed    | Elementary/Secondary (0-12)  | College (1-4 c  | or 5+)                         |  | O NOT use retired)   |                         |   | D                       |  |                                 |        |  |
| d 2<br>ed wii<br>Hygie<br>other  | Be           | 17. Father's Name (First, Middle, i  | ast)  |                                | Dare   |  | 18 Mother's             | Name (First, Middle,                        | Retai                   |  |                                 |        |  |
| be fill lental rked circ eve   | 2            | Horace Bullman   | ,   |                                |  |  |                         | ie Groce                                    |                         |  |                                 |        |  |
| ary hould and M is mai   |              | 19a. Informant's Name/Relations  |   |                                | 19b. Mailin                                      | g Address (Street a  | and Number o            | r Rural Route Numbe                         | er, City or Town        | n, State, Zip C                                    | iode)                           |        |  |
| , M<br>nd 2 s<br>sauth a<br>n 27 i<br>er tra   |              | Barbara Kontas   | /Daughter   |                                | 1214   | Gladstor   | ne Driv                 | ve, Rockvi                                  | 11e, M                  | D 2085   | 1                               |        |  |
| Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other   |              | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S | Specify)  | ate Ph1                        | lace of Dispo<br>emetery, cren<br>Ladelp<br>urch | sition (Name of<br>natory or other plac<br>hia Bapt<br>emetery | ist A                   | pril 16<br>2012                             | 20c. Location           | on - City or To                                    | wn, State                       |        |  |
| Bal<br>permit<br>Depar<br>Impor<br>any in  |              | 21. Signature of Funeral Service I   | icensee   | 9                              |  |  |                         | ns Funeral<br>lvd. W., S                    |                         |  | MD 2090                         | 1      |  |
| 1  |              | 23a. Part 1. Emer the disease, or shock, or heart failure. List of             | complications that cause  | sed the death<br>line.         |  |  |                         |   |                         |  | Approximate<br>Interval Between |        |  |
| ~ Ph <sub>sician</sub> /   |              | Immediate Cause (Final disease or condition                                    |   |                                | f Extr   | emities  |                         |   |                         |  | Onset and Dea                   |        |  |
| Medical Examiner   |              | resulting in death)  |   | as a cons <del>e</del> qu      |  |  |                         |   |                         |  |                                 |        |  |
|  | -            | Sequentially list conditions,  | b. Debili   | ty<br>as a consequ             | longo of:  |  |                         |   |                         | _  |                                 |        |  |
| ed <del>j</del>  | Examiner     | if any, leading to immediate cause. Enter University Cause (Disease or injury  | Due to (or a  | as a consequ                   | erice oij.                                       |  |                         |   |                         |  |                                 |        |  |
| be executed sician and buriates  | Exa          | that initiated events resulting in death) Last                                 | C. Due to (or   | as a consequ                   | ence of):  |  |                         |   |                         |  |                                 |        |  |
| te be e  | dical        |  | d   |                                |  |  |                         |   |                         |  |                                 |        |  |
| 68/6<br>certificate<br>nding phy<br>use as th  | Med          | IF FEMALE:   | 1   |                                |  |  |                         |   |                         |  |                                 |        |  |
| ords, P.O. Box 68/60 requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burn to the second or the burn to the bu |              | 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown        | 23c. If yes, outcor 1   | th 2 🗀 Feta<br>nt at time of d | I death 3  | Ectopic pregnanc Other (specify)                               | У                       |   |                         | Date of delive<br>Month                            | ery<br>Day Year                 |        |  |
| that the ned by the detack   |              | Part II. Other significant condition   | ons contributing to deat  | h but not resu                 | ulting in the u                                  | nderlying cause giv  | en in Part I.           | 23e. Did t                                  | obacco use co           | ontribute to th                                    | e cause of death?               |        |  |
| S, F   | d by         | Dementia   |   |                                |  |  |                         | 1 🗆   | Yes 2 N                 | o 3 🗆 Prot   | pably 4 🔀 Unkno                 | own    |  |
| ord / requ   | Completed    |  |   |                                |  |  |                         | 24a. Was                                    | an 24                   |  | osy findings availat            |        |  |
| (eco   | mo<br>U      |  |   |                                |  |  |                         |   | psy<br>ormed?<br>2 X No | prior to cor<br>death?<br>1 \sum Yes               | mpletion of cause of            | )t     |  |
| an: T<br>an: T<br>tifficar<br>stor, p  | BeC          | 25. Was case referred to medical   |   |                                | 53-785-1-1                                       | 26. Pla  | ace of Death            | Check only one)                             |                         |  |                                 |        |  |
| VIT nysici   | 2            | examiner?<br>1 Yes 2 No  | Hospital:   | patient 2 🗆                    | ER/Outpatier                                     | t 3 🗆 DOA Othe   | er:<br>4 🗌 Nursir       | ng Home 5 🗆 Resi                            | dence 6X                | Hospic<br>Other (Specify)                          | e                               |        |  |
| ing Pl   | ate:         | 27. Manner of Death 1 X Natural 5 ☐ Pendii                                     | 28a. Date of i  | injury<br><i>Day, Year)</i>    | 28b. Time of<br>injury                           | 28c. Injury<br>work  | ?                       | 28d. Describe t                             | now injury occ          | urred  |                                 |        |  |
| ttend<br>death<br>death<br>tor: A  | Certificate: | 2 Accident Investi   | gation<br>not be  | latina AA ba                   |  |  | Yes 2 No                |   |                         |  | D. to Mood                      |        |  |
| To the Hospital or Attending Physician: The law requires within 24 hours after death.  To the Funeral Director: After this certificate has been signorpletely filled in by the funeral director, page 2 should the completely filled in by the funeral director, page 2 should be a second to the complete of  |              | 4 Homicide determ  | building,   | etc. (Specify)                 | )  | eet, factory, office   |                         | City or Tov                                 | vn, State)              |  | Route Number,                   |        |  |
| he Hosp<br>in 24 hou<br>he Funei<br>pletely fi   | Medical      | (Check 2 Medical I   | Physician: To the best<br>examiner: On the basis of<br>Nurse Practitioner: To | of examination                 | and/or invest                                    | igation, in my opinic  | n, death occur          | rred at the time, date a                    | and place, and          | due to the cau                                     | use(s) and manner s             | tated. |  |
| Vith With Com  |              | 29b. Signature and title of certifie   | 96/   |                                |  | 29c. License   |                         |   | 29d. Date sig           | ned (Month, E                                      |                                 |        |  |
|  |              | 30. Name and address of person G. Coleman, M                                   |   |                                |  |  | ockvil                  | le, MD 208                                  |                         |  |                                 |        |  |
| Stat   | е            | 31. Date filed (Month, Day, Year)  | 32. Regi  | strar's Signat                 | ure  |  |                         |   |                         |  |                                 |        |  |
| Registra   | ır           | APR 16 2   | 012 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2                                       | w A.                           | par  | (d).   |                         |   |                         |  |                                 |        |  |
| DHMH 17 Rev 06-2   | 011          |  | /   |                                |  | 1-1  |                         |   |                         |  |                                 |        |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 14588 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 17 Day 2012 ROSWELL WHITMYER 8:43PM M SR. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours **Director** 579 50 2134 71 1 X M 2 | F JUNE 9 1940 WASH. DC Usual Residence of Decedent 28a-f show 10a. State 10b. County Ħ 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a SUITLAND MD XX Yes 2 No PG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5000 LYDIANNA LANE #230 20746 USA items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify item 27 is marked other than "natural", other traumatic event, the Medical Exal Specify: BLACK 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education . Kind of Business/Industry FEDERAL (Specify only highest grade completed) Il Hygiene. other than " College (1-4 or 5+) Elementary/Secondary (0-12) GOVERNMENT INSPECTOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental File of Health and Mental Fitem 27 is marked of FLEMION WHITMYER GLADYS JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5000 LYDIANNA LANE #230 SUITLAND MD 20746 MARY WHITMYER/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ō 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/24/12 CLINTON MD RESURRECTION CEM 21. Si maure on Funeral Service Licentee 22. Name and Address of Facility CC0527 WATSON FH 3435 14th ST NW WASH DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Examiner RESPIRATORY FAILURE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) PNEUMONIA -transit BALTERIAL To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician for use as the burial Physician/Medical KIDNEY DISEASE P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Vear Pregnant at time of death the 8 Unknown 9 Unknown signed by the Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ANEMIA Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 18 No 1 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this
completely filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar

TAKOMA PARK MD. 31. Date filed (Month, Day, Year) 23

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charebeleh

7600 CARROLL AVE.

MD 52855

20912

8-2012

CHANDRA KORAPATI MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                                |  |              | State of Maryland / Dep   | artment of He   |                                |                                    | 201  | 2 14589                            |
|--------------------------------|--|--------------|---|---|--------------------------------|------------------------------------|--|------------------------------------|
|                                |  | -            | Registrar  1. Decedent's Name (First, Middle, Last)   | rimouto or Bo   | - I                            | 2. Date of Death                   | g. No.   | 3. Time of Death                   |
|                                | Physicia   |              | Hong Kee Yee  |   |                                | April 19                           | 9, 2012 Year   | 3:01 p <sup>M</sup>                |
|                                | Medic<br>Examin  |              | 4a. Facility Name (if not institution, give street and number)  | 4b. City, Town, or Lo                                   | ocation of Death               |                                    | 4c. County of Death                                    |                                    |
| -1                             | 7  |              | Medstar Montgomery Medical Center   | Olney   |                                |                                    | Montgor  | nery                               |
|                                | Funeral  |              | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 6. Tyrs. 1 3 1 3 1 2 5 7 7 5 1 2 5 7 7 5 1 3 1 3 1 3 1 3 1 3 1 3 1 3 1 3 1 3 1  |   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day, Y | (ear) 9. Birti   | nplace (State or Foreign<br>Intry) |
|                                | Director   |              | 5//-5U-9/31 1   Usual Residence of Decedent 1   Yrs. 1   Yrs. 1   Yrs. 2   F   77   Yrs. 1   Yrs. 1 | 1 1 1   |                                | Nov. 29,                           | 1934   | China                              |
|                                | show<br>show   | or           | 10a. State 10b. County 10c. City, Town or Lo  | ocation   |                                |                                    |  | 10d. Inside City Limits            |
|                                | Aaryla<br>8a-f   | Director     | MD Montgomery Rockv   | ille  |                                |                                    |  | 1 Yes 2 X No                       |
|                                | the la or 2 be no  | i Di         | 10e. Street and Number  | 10f. Zip Code   |                                | 10                                 | g. Citizen of What Co                                  | untry?                             |
|                                | ns 23  | Funeral      | 13501 Crispin Way   | 20853   |                                |                                    | USA  |                                    |
| 39                             | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.   | by           | 11. Marital Status  1  Never Married 2  Married  3  Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2  No  If Yes, Give  Year or Dates.   | Was Decedent of Hisp<br>If Yes, specify Cuban, I        |                                | cify Yes or No-<br>Rican, etc.)    | 14. Race - Amer<br>Black, White<br>Specify: <b>Asi</b> | , etc.                             |
| 9                              | hours<br>natur<br>ical E   | lete         | 15. Decedent's Education 16a. Dece  | edent's Usual Occupation                                | on                             | 1                                  | 6b. Kind of Business/l                                 | ndustry                            |
| 215                            | n 72<br>s.<br>ian "r<br>Med  | Completed    | Elementary/Secondary (0-12) College (1-4 or 5+) life. L   | kind of work done duri<br>OO NOT use retired)           | ing most of worki              | ng                                 |  |                                    |
| 7                              | withing report of the control of the |              | 6 Root  | fer   |                                |                                    | Construct  | ion                                |
| nd                             | e filec<br>ital Hi<br>ed otl   | To Be        | 17. Father's Name (First, Middle, Last)   | 1   |                                | e (First, Middle, Ma               | aiden Surname)   |                                    |
| <u> </u>                       | uld be<br>d Men<br>narke<br>natic  |              | Yuk Yee   |   |                                | ng Wong_                           | T 011 7  | 0.10                               |
| Ma                             | 2 sho<br>th and<br>27 is u   | - Y          | 1   | ing Address (Street and<br>l Crispin W                  |                                |                                    |  | Code)                              |
| Baltimore, Maryland 21215-0036 | I and<br>I Heal<br>Item  |              | 20a. Method of Disposition 20b. Place of Disp   | osition (Name of  | [                              | Date 2                             | Oc. Location - City or                                 | Town, State                        |
| υO                             | age 1<br>ent of<br>nt: If i  |              | 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Parklawn  | matory or other place) Memorial P                       | ark Apr                        | 11 26,<br>2012 R                   | Rockville,   | MD                                 |
| al<br>Ei                       | mit. F<br>oartm<br>oorta<br>/ inju   |              |   | Z Name and Address                                      | Cogility ins                   |                                    |  |                                    |
| m                              | Depar<br>Depar<br>Impo<br>any ir   | 723          | Jumes & Jacky 5   | 00 Univers  | ity Blvd                       | . W. S11                           | ver Spring   | 5,                                 |
|                                |  |              | 23a. Part 1/Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.   |   |                                |                                    | t,   | Approximate<br>Interval Between    |
| -                              | hysician/  | l III        | Immediate Cause (Final disease or condition   | ocardial.   | Infarc                         | han                                |  | Onset and Death                    |
| المردوب                        | Medical Examiner   |              | resulting in death)  Due to or as a consequence of  |   | ,                              | - 7000                             | 1  |                                    |
|                                |  | er           | Sequentially list conditions, ir any, leading to immediate b. Due to (or as a consequence or).  |   |                                |                                    |  |                                    |
|                                | Unsit ed   | Examiner     | cause. Enter Underlying Cause (Disease or injury  |   |                                |                                    |  |                                    |
|                                | n and  | Exa          | that initiated events resulting in death) Last C. Due to (or as a consequence of):  |   |                                |                                    |  |                                    |
| 00                             | ite be executed hysician and the burlal-transit  | dical        | d   |   |                                |                                    |  |                                    |
| 876                            | eath certificate<br>attending phy<br>I for use as th   | Med          | IF FEMALE:  |   |                                |                                    |  |                                    |
| Box 687                        | th cer<br>ttendi<br>or use   | Physician/Me |   | Ectopic pregnancy                                       |                                |                                    | 23d. Date of del<br>Month                              | very<br>Dav Year                   |
| Bo                             | e dea<br>the a   | ysic         | 1   Yes 2   No   4   Pregnant at time of death 5   9   Unknown   5  | Other (specify)   |                                |                                    |  | ,                                  |
| P.O.                           | hat th   |              | Part II. Other significant conditions contributing to death but not resulting in the  | underlying cause giver                                  | n in Part I.                   | 23e. Did toba                      | acco use contribute to                                 | the cause of death?                |
| s, F                           | ires ti<br>sign  | d by         | CHF MI, DM  |   | <u> </u>                       | 1 🗆 Yes                            | s 2 🗆 No 3 🗆 Pr  | obably 4 Unknown                   |
| ord                            | v requ   | olete        |   |   |                                | 24a. Was an                        |  | opsy findings available            |
| Sec.                           | he lav<br>te has<br>age 2  | Completed    |   |   | *                              | autopsy<br>perform<br>1 \sum Yes 2 | ed? death?   | completion of cause of             |
| a<br>F                         | ian: T   | BeC          | 25. Was case referred to medical examiner?  | 26. Place   | e of Death (Check              |                                    | 21101 12 130   |                                    |
| ₹                              | hysic<br>nis ce<br>il direc  | မ            | 1 ☐ Yes 2 ☐ No ☐ Hospital. 1 ☐ Inpatient 2 ☐ ER/Outpatie  | ent 3 DOA Other:  | 4 Nursing Ho                   | me 5 🗌 Residen                     | ice 6 Other (Speci                                     | fy)                                |
| 10                             | ing Pl   | ate:         | 27. Manner of Death 28a. Date of injury 1 → Natural 5 → Pending (Month, Day, Year) injury   | work?   |                                | 28d. Describe how                  | v injury occurred                                      |                                    |
| <u>i</u>                       | ttend<br>death<br>tor: A   | Certificate: | 2 Accident Investigation 3 Suicide 6 Could not be   |   | es 2 🗆 No                      | 20f Location (Stro                 | eet and Number or Rui                                  | al Pouto Number                    |
| Division of Vital Records,     | l or A<br>after<br>Direc   | Cer          | 4 Homicide determined building, etc. (Specify)  | reet, factory, office                                   |                                | City or Town,                      |  | ai rioute rumbei,                  |
|                                | To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending of completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the complete of the comp | Medical      | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inve  | stigation, in my opinion,                               | death occurred at              | the time, date and                 | place, and due to the o                                | ause(s) and manner stated.         |
|                                | o the<br>vithin (<br>o the<br>omple  | ž            | only one) 3 Certifying Nurse Practitioner: To the best of my knowledg  29b. Signature and title of certifier  | e, death occurred at the                                | time, date and pla<br>jumber   | ice, and due to the                | cause(s) and manner as<br>d. Date signed (Month        | stated.<br>, Day, Year)            |
|                                | 12   |              | I Walnut the mis Dest   | EM DOQ  | 50410                          |                                    | 4/20/1   | 2                                  |
|                                | ,  |              | 30. Name and address of person who completed cause of death (Item 23a) (Type,   | Print)  | 2//                            | 1 01                               | ,  |                                    |
|                                |  |              | Michael Kerr and 1810   | Pomes 1   | pilip                          | Dr 011                             | ny 200   | 732                                |
|                                | Sta<br>Registra  |              | 31. Date filed (Month, Day, Year)  APR 2 3 2012  32. Registrar's Signature  | e, death occurred at the 29c. License ni EM DOOL Print) |                                |                                    | -  |                                    |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>2012 Physician/ April 18, 4:45 Louise Waldecker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Suburban Hospital Bethesda 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, **Funeral** Hours Days Months 579-22-8765 **Director** 1 □ M 2 🗓 F 90 March 27, 1922 Washington, DC Usual Residence of Decedent 28a-f shov 10b. County items 23a or 28a-r sno-ner must be notified at 10c. City, Town or Location Director 1 Yes 2 TNo Kensington MD Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20895 USA 3812 Decatur Avenue Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status ed other than "natural", or iter event, the Medical Examiner Armed Forces and 2 should be filed within 72 hours after c Health and Mental Hygiene. tem 27 is marked other than "natural", or wher traumatic event, the Medical Examin 1 Never Married 2 X Married ☐ Yes 2 X No ğ Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Marie Catherine Kettner Bernard Shreve 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 3812 Decatur Avenue, Kensington, MD 20895 Irvine Quentin Waldecker/Husbard 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State April 24 2012\_ 4 ☐ Donation 5 ₺ Other (Specify)entombment Gate of Heaven Cemetery Silver Spring, MD 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death II days Immediate Cause (Final Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Septic Shock days Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): burial-transit Hypoxic Hypercarbic Respiratory Failure Cause (Disease or injury that initiated events 11 davs resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year detached -18-2012 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò page 2 should be 1 Yes 2 No 3 Probably 4 Munknown Completed Coronary Artery Disease, Pulmonary Sarcoidosis 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy performe 1 Yes 2 No Yes 2 X No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \sum \) Nursing Home 5 \( \sum \) Residence 6 \( \sum \) Other (Specify) 2 DaNo ျ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral ( 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending 1 Yes 2 No within 24 hours after death

To the Funeral Director: A

completely filled in by the fi Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) シュー ()-April 18, 2012 D71517 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, MD 20814 Natalia M. Vasquez, MD

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year) APR 2 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 29<sup>Day</sup> Physician/ GEORGE M. WHITE April 2012 10:00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Towson Gilchrist Hospice Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 54 Yr. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 213-70-4987 Months Days Hours (Month, Day, Year) **Director** 1 **X** M 2 □ F Jan. 11,1958 Baltimore, MD Usual Residence of Decedent 28a-f show d Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7 North Rose St. 21224 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction 10 Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Catherine E. Moor Raymond P. White permit. Page 1 and 2 should be f Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claude B. Welch (bro-in-law) 2904 Jefferson Road, Spring Grove, PA 17362 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 x Cremation 3 x Removal from State cemetery, crematory or other place) May 1,2012 York, PA 17403 4 ☐ Donation 5 ☐ Other (Specify) White Rose Crematory 21. Signature of F 22. Name and Address of Facility Geiple Funeral Home Inc. #CC0265 53 Main St. Glen Rock, PA 17327 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ metastatic adenocacinna disease or condition hintry Medical resulting in death) Due to (or as a consequence of): Examiner unontus noboble Colon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine to (or as a consequence of) Cause (Disease or injury that initiated events sician and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Day Year Pregnant at time of death signed by the aid 1 Yes 2 9 Unknown 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy performed? Yes 2 certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 - Nursing Home 5 - Residence 6 Other (Specify) 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

m

State Registrar

WARRES 31. Date filed (Month, Day, Year) MAY 0 8 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

atitle of certifie

(201 N Charles

303

29d. Date signed (Month, Day, Year) 30

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                    |  |                   | For<br>State<br>Registrar   | State of Mary  |                              | rtificate of   | Death   | Reg  | 1. No. 201                                    | 2 14592                            |  |  |
|--------------------|--|-------------------|---|--|------------------------------|--|---|--|---|------------------------------------|--|--|
|                    | Physicia   | an                | 1. Decedent's Name (First, Middle   |  |                              |  |   | <ol><li>Date of Death<br/>Month</li></ol>      | Day Year                                      | 3. Time of Death                   |  |  |
| Mag                | /Medic   | ai                | Evelyn Mae Zep  |  |                              | T =  | or Location of Death                            | April 12                                       |   | 8:45 a. <sup>M</sup>               |  |  |
|                    | Examin   | er                | 4a. Facility Name (If not institution, Long View Nurs   | _  |                              | 4c. County of Death                                  |   |  |   |                                    |  |  |
|                    | Funeral  |                   |   |  | yrs. last birthday)          | If Under 1 Year                                      | anchester  If Under 24 Hrs.                     | 8. Date of Birth<br>(Month, Day, Y             |   | nplace (State or Foreign<br>untry) |  |  |
| и                  | Director   |                   | 217-18-8310   | 1□ M 2 <b>3 x</b> F 88   | Yrs.                         | Months Days  | Hours Min.                                      | (Month, Day, Y                                 | (ear) Cou                                     | MD                                 |  |  |
|                    | pui w  |                   | Usual Residence of Decedent  10a. State 10b. County   | 100  | c. City, Town or Lo          | ocation  |   |  |   | 10d. Inside City Limits            |  |  |
|                    | faryla<br>f sho  | ō                 |   | roll   | Hampste                      |  |   |  |   | 1 ☐ Yes 2 ☑ No                     |  |  |
|                    | the N  | Director          | 10e. Street and Number  |  |                              | 10f. Zip Code  |   | 100  | 2. Citizen of What Cou                        | itizen of What Country?            |  |  |
|                    | 23a or   | ral Di            | 4418 Black Roc  | k Rd. Apt 8  |                              |  | 1074  |  | USA   |                                    |  |  |
|                    | tems   | Funeral           | 11. Marital Status  | 12. Was Decedent Ever<br>Armed Forces?   | in U.S. 13.                  | Was Decedent of I<br>If Yes, specify Cub             | Hispanic Origin? (Spec<br>an, Mexican, Puerto R | cify Yes or No-<br>lican, etc.)                | 14. Race - Amer<br>Black, White               |                                    |  |  |
| 5-0036             | s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "violal Experiment mast be notified at | þ                 | M Never Married 2  Marri<br>3  Widowed 4  Divorced  | ed 1   |                              | 1 □Yes 2X No   | Specify:  |  | Specify: W                                    | hite                               |  |  |
| 15-(               | "natu  | Completed         | 15. Decedent<br>(Specify only highes  | s Education<br>t grade completed)  | 16a. Dece                    | edent's Usual Occup<br>kind of work done             | pation<br>during most of working<br>d)          | g 16   | 6b. Kind of Business/I                        | ndustry                            |  |  |
| 2121               | 2 should be filed withir<br>and Mental Hygiene.<br>is marked other than<br>aumatic event, he M   | dwo               | Elementary/Secondary (0-12)   | College (1-4or 5+)   | į.                           | okkeeper   | u)  |  | Reistersto                                    | um Limber                          |  |  |
|                    | illed<br>Il Hyg<br>other   | Be C              | 17. Father's Name (First, Middle, L   | ast)   |                              | ORRECPEL   | 18. Mother's Name                               |  |   | WII HUMBEL                         |  |  |
| /lan               | Alenta<br>Nenta<br>rked<br>tic ev  | To B              | Emory J. Zepp   |  | Mabel                        | D. Uhle  | er  |  |   |                                    |  |  |
| Maryland           | should and Men is marke  |                   | 19a. Informant's Name/Relationsh  |  | and Number or Rural          |  |   | ip Code)                                       |   |                                    |  |  |
| _                  | 1 and 2<br>Health<br>em 27<br>ther tra   |                   | Robert R. Zepp  |  |                              |  | Drive, Ham                                      | <u>-                                      </u> |   |                                    |  |  |
| <b>Baltimore</b> , | permit. Pages 1 a Department of Hee Important: If item any injury or othe  |                   | 20a. Method of Disposition  1 ☐ Burial 2 ☒ Cremation  4 ☐ Donation 5 ☐ Other (Sp  | 3 ☐ Removal from State   |                              | osition (Name of<br>matory or other pla<br>Cremation |   |  | oc. Location - City or Tempstead, 1           |                                    |  |  |
| Balt               | permit. Departr Imports any inji   |                   | 21. Signature of Funeral Service L  | icensee M0074  |                              | 2. Name and Addre                                    | ess of Facility Ellin Street,                   |  | eral Home                                     | 74                                 |  |  |
|                    |  |                   | 23a. Part 1. Enter the disease, or shock, or heart failure. List of   | complications that caused the  |                              |  |   |  |   | Approximate<br>Interval Between    |  |  |
| J. Car             | Physician  | 4                 | Immediate Cause (Final disease or condition   | Corrections 22   | twe 7                        | Levet Fra  | ilure 1   | CHF)   |   | Onset and Death                    |  |  |
|                    | /Medical   |                   | resulting in death)   | Due to (or as a co   |                              |  | 0 0   |  | 160-1   | 1000                               |  |  |
|                    | Examiner   | _                 | Sequentially list conditions.   | D  | sclerat                      | ic level   | brovsaulo                                       | E WASER  | se(ASCVD)                                     | 25yes.                             |  |  |
|                    | led sit  | nine              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a co   | nsequence of):               | ting P.O.  | not an a fee of.                                | 101.00   | (000)   | 2011/4:                            |  |  |
|                    | execurand and  | Examiner          | that initiated events<br>resulting in death) Last   | c. Due to (or as a co  | nsequence of):               | 700-100  | The same  | accie  | (WID)   | Soyce                              |  |  |
| 68760              | icate be executed<br>physician and<br>the burial-transit   |                   |   | d  |                              |  |   |  | Į.  |                                    |  |  |
| 89                 | tificat<br>ng phy<br>as the  | <b>Jedical</b>    |   |  |                              |  |   |  |   |                                    |  |  |
| Вох                | attendin<br>for use  | an/N              | 23b. Was decedent pregnant  | 23c. If yes, outcome of p  |                              | ☐ Ectopic pregnan                                    | cv  |  | 23d. Date of deli                             | ,                                  |  |  |
| O. E               | Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit                                   | Physician/        | in the past 12 months?<br>1 □Yes 2 No<br>9 □ Unknown  | 4 ☐ Pregnant at tim<br>9 ☐ Unknown   |                              | Other (specify)                                      |   |  | Month   | Day Year                           |  |  |
| σ.                 | res that<br>signed by<br>be deta   |                   | Part II. Other significant condition  | ns contributing to death but no  | ot resulting in the ι        | ınderlying cause gi                                  | ven in Part I.                                  | 23e. Did toba                                  | cco use contribute to                         | the cause of death?                |  |  |
| Records,           | w requires<br>been sign<br>should be   | ed by             |   |  |                              |  |   | 1 ☐ Yes  | 2 No 3 □ Pr                                   | obably 4 Unknown                   |  |  |
| ဝ၁                 | e law re-<br>has bee<br>le 2 sho   | Completed         |   |  |                              |  |   | 24a. Was an                                    |   | topsy findings available           |  |  |
| Ä                  | The I  | mo                |   |  |                              |  |   | autopsy perform                                | ed? death?                                    | completion of cause of<br>2 □ No   |  |  |
| Vital              | sician; Th<br>certificate<br>rector, pag   | Be C              | 25. Was case referred to medical examiner?  |  |                              |  | 26. Place of Death                              |  | -   |                                    |  |  |
| of \               | Physic<br>rthis c  |                   | 1 ☐ Yes 2 No  |  | 2 ER/Outpatie                | mt 3 DOA   |   |  | ce 6 Other (Spec                              | cify)                              |  |  |
|                    | ding F<br>h.<br>After<br>funera  | ion:              | 27. Manner of Death 1 Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day, Ye   | ar) 28b. Time o              | Wo   | rk?   | 8d. Describe how                               | injury occurred                               |                                    |  |  |
| Division           | death<br>ctor:<br>/ the  | icat              | 2 Accident investig<br>3 Suicide 6 Could n  | ot be  | At home farm st              |  | Yes 2 □No                                       | 8f Location (Stre                              | eet and Number or Ru                          | ural Route Number                  |  |  |
| Ρį                 | after after I Direct   | Certification: To | 4 ☐ Homicide determi  | building, etc. (S  | Specify)                     |  |   | City or Town,                                  | State)  | nai Heate Hamber,                  |  |  |
|                    | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer   | Medical C         | 29a. Certifier (Check only one)  Certifying  Medical I  | g Physician: To the best of m<br>Examiner: On the basis of exa<br>and manner stated. | amination and/or in          | nvestigation, in my                                  | opinion, death occurre                          | ed at the time, dat                            | use(s) and manner as<br>te and place, and due | s stated.<br>to the cause(s)       |  |  |
|                    | To the within To the compl   | Me                | 29b. Signature and title of certifier   | . 0 0 1  | 7 ^                          | 29c. Licen   | se number                                       | 290  | d. Date signed (Monti                         | h, Day, Year)                      |  |  |
|                    |  |                   | ▶ Gracel  | Z. Kybelg  | J. D. O.                     | HO   | 06/206  |  | 4/13/12                                       | 2                                  |  |  |
| U                  | 742  |                   | 30. Name and address of person v  | who completed dause of death   | (Item,23a) (Type,<br>estmin. | Ster 1   | se number<br>2061206<br>ND 211                  | 57/TR  | Racie L. Ry                                   | berg DO                            |  |  |
|                    | Sta<br>Registr   |                   | 31. Date filed (Month, Day, Year)   | 2012 Registrar's   | Signature                    | ake  |   | î  |   | 0                                  |  |  |

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY G927 5/09/2012 III State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 Month Physician 子尺けれ K 利止 3月 f 4a. Facility Name (If not institution, give street and number) ALBANESE ,2012 MIAY /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** N/A Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X**□M 2□F Months Days Hours Min Yrs. **Director** 232-42-5370 5,1921 West Virginia Aug. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show 1 ☐ Yes 2 No Director Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 s any Injury or other traumatic event, the Medical Examiner must be notified MD Baltimore Dunda1k 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Funeral 974 Dalton Avenue 21224 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 Divorced WWII White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Locke Insulation 12 Years Inspector unkn 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unkn. Be r is marked ot ၉ 19a. Informant's Name/Relationship (Type. Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mildred E. Albanese Baltimore, Maryland 974 Dalton Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem. 5/7/2012 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hartsock, Jr Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee Paul 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final PUL MONNRY

Due to (or as a consequence of) HEMORRHAGE Physician HOUR disease or condition resulting in death) /Medical Examiner MONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician and use as the burial-transit Due to (or as a consequence of) attending physician Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal dea 4 Pregnant at time of death 2 🗌 Fetal death 3 Ectopic pregnancy ₽ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the at detached f 9 Unknown P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \sum Nursing Home ≥ ER/Outpatient 3 □ DOA 2 No 5 Residence 6 Other (Specify) မ this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred re Hospital or Attending P n 24 hours after death. re Funeral Director: After the Certification: 5 Pending investigation 1 Natural Injury 2 Accident 1 Tes 2 No 3 🗌 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 - Homicide City or Town, State) 29a. Certifier (check only 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0063303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EZHL MD 4940 Eastern Avenue, Baltimore, MD, 21224 KO DICA 31. Date filed (Month, Day, Year)
NAY 0 9 2012

DHMH 17 Rev 1/2001 11595

State Registrar

| 12-03401      |  |
|---------------|--|
| Albert Augson |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

| ibert / tages  | 1- For State   | Certificate of Deat                     | h  | Reg. No. 201   | 2 1459   |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|
| Physician/   | Registrar  1. Decedent's Name (First, Middle,Last)   |   | 2. Date of<br>Month  | Day Year   | 3. Time of Death<br>1835 hrs                   |  |  |  |  |
| Medical Examiner   |  | son, Jr.                                | May 2  | 4c. County of Death  | 1033 1115                                      |  |  |  |  |
|  | Facility Name (if not institution, give street and number)     18717 Flower Hill Way   |   | ersburg  | Montgomery   |  |  |  |  |  |
| Funeral  |  | \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \   |  | of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign           |  |  |  |  |  |
| Director   | 228-94-9949 1XM 2F 5   | 2 Yrs. Month                            | ns Days Hours Min. May   | 19, 1959 Cou   | Virginia                                       |  |  |  |  |
| any  | Usual Residence of Decedent  10a. State 10b. County 11   | 0c. City, Town or Location              |  |  | 10d. Inside City Limits                        |  |  |  |  |
|  | Maryland Montgomery  | Gaithersbu                              | rg   |  | 1 Yes 2 No                                     |  |  |  |  |
| the Maryland a or 28a-f show tified at once. Director  | 10e. Street and Number   | 10f. Zij                                | Code   | 10g. Citizen of What Coun                                      | try?   |  |  |  |  |
| h the 3a or solifice   | 18717 Flower Hill Way 20879 United State 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American State S |   |  |  |  |  |  |  |  |
| r death with the Maryland<br>or items 23a or 28a-f sho<br>must be notified at once<br>Funeral Director   | 11. Marital Status 1 Never Married 2 Married 2 Married Armed Forces?   | If Yes, spec                            | ent of Hispanic Origin? ( Specify Yes o<br>fy Cuban, Mexican, Puerto Rican, etc. | or No- 14. Race - Americ<br>) White, etc.                      | carrindian, black,                             |  |  |  |  |
| ter des<br>r, or i<br>cr mu  | 1 X Yes 2 2 3 Widowed 4 Divorced If Yes, Give Year 1982  | No<br>2-2002 1 Yes 2                    | X No specify:  | Specify: B1a   | ack  |  |  |  |  |
| atural" samine   | 15. Decedent's Education (Specify only highest grade compl   |   | Occupation (Give kind of work done rking life, DO NOT use retired)               | 16b. Kind of Business/Ir                                       | ndustry  |  |  |  |  |
| 6<br>72 hc<br>cal Es   | Elementary/Secondary (0-12) College (1-4 or 5+   | .)                                      |  | Computers  |  |  |  |  |  |
| 5-0036 led within 72 hours after they write "natural", other than "natural", the Medical Examines Completed by   | 17. Father's Name (First, Middle, Last)  | Systems E                               | 18 Mother's Name (First, Mid   |  | •        |  |  |  |  |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than ic event, the Medica TO Be Comple   | Albert Augson, Sr.   |   | Mary Dupree  |  |  |  |  |  |  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be fifed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director | 19a. Informant's Name/Relationship (Type, Print )  |   | (Street and Number or Rural Route  |  |  |  |  |  |  |
| MD nd 2 shc alth and z 7 is  | Truda Augson / Wife 20a. Method of Disposition   | 812 Gallo 20b. Place of Disposition (Na | p Hill Road, Apt. me of cermetery, Unk. Date                                     | E, Gaithersbul   | rg, MD 20879 Town, State                       |  |  |  |  |
| Ore,   | 1 X Burial 2 Cremation 3 Removal from State  | crematory or other place                | )  | Arlington,   | Virginia                                       |  |  |  |  |
| Baltimore,<br>permit. Pages 1 a<br>Department of He<br>Important: If ite<br>injury or other tr   | 4 Donation 5 Other Specify: 21. Signature of Vineral Service Licensee  | Arlington Nationa                       | Address of Cosiling  |  |  |  |  |  |  |
| Balti<br>permit.<br>Departu<br>Importa<br>injury e   | Modella Barard M   | 01305   Robert A                        | Pumphrey Funeral Ho<br>Montgomery Avenue, R                                      | me/Rockville, In<br>ockville, Marylar                          | d 20850-2805                                   |  |  |  |  |
| Physician  | 23a. Pard. Enfer the disease, or complications that caused the failure. List only one cause on each line.  | ne death. Do not enter the mode         | of dying, such as cardiac or respirator  | y arrest, shock, or heart                                      | Approximate Interval<br>Between Onset and      |  |  |  |  |
| Micdical<br>Examiner   | Immediate Cause (Final disease a. Hypertensive Ath or condition resulting in death)  Due to (or as a conseq  | erosclerotic Cardiovasc                 | ular Disease   |  | Death  |  |  |  |  |
|  | h  | uence or).                              |  |  |  |  |  |  |  |
| iner   | Sequentially list conditions, if any, leading to immediate  cause. Enter Underlying Cause  | quence of):                             |  |  |  |  |  |  |  |
| ted<br>Insit<br>Examine  | (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence)  | uence of):                              | · · · · · ·  |  |  |  |  |  |  |
| execul<br>ian and<br>ial - tra   | d.  UNPENDED AMENDED   |   |  |  |  |  |  |  |  |
| 760, icate be the burning the burning //Med  | IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the  |   | 3 Ectopic pregnancy  | 23d. Date of delivery<br>Month D                               | ay Year  |  |  |  |  |
| b. Box 687 the death certific by the attending teched for use as the   | past 12 months?  |   | _  | la l                       |  |  |  |  |  |
| Bo<br>ne deat<br>the at  | 1 Yes 2 No 9 Unknown 9 Unknown   | but not resulting in the underlyin      | g cause given in Part I 23e  | Did tobacco use contribute to                                  | the cause of death?                            |  |  |  |  |
| cords, P.O. Box 687 aw requires that the death certific has been signed by the attending I 2 should be detached for use as it npleted by Physician!  | chronic alcoholism   | but not resulting in the dilderlyin     | 1  | Yes 2 No 3 Prob  |  |  |  |  |  |
| Records,   The law requires firete has been significate been significate been significate been significate been significated.  |  |   |  |  | topsy findings available ompletion of cause of |  |  |  |  |
| Division of Vital Records, ra or Attending Physician: The law requir its after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should bertification: To Be Completed   |  |   |  | autopsy prior to c<br>performed? death?<br>Yes 2 No 1 ✔ Ye     |  |  |  |  |  |
| n: The difficat Cor, pag   | 25. Was case referred to medical   |   | 26.Place of Death (Check only one)   |  |  |  |  |  |  |
| F Vital Physician This certifial director  | examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatien   |   |  | 5 Residence 6 Other  | : Scene  |  |  |  |  |
| After funera   | 27. Manner of Death 28a. Date of Injury (Month, Day,Yet  | y 28b. Time of Injury<br>ar)            | 28c. Injury at Work? 28d. Desc<br>1 Yes 2 No                                     | cribe how injury occurred                                      |  |  |  |  |  |
| Sior<br>Attenc<br>r death<br>cctor:<br>by the  | 2 Accident Investigation 28e Place of Inju   | ıry - At home, farm, street, factor     | ALCOHOLD TO A STREET   | tion (Street and Number or Ru                                  | ral Route Number, City                         |  |  |  |  |
| Division or spital or Attending tours after death.  neral Director: After filled in by the func Certification:   | 3 Suicide 6 Could not be determined (Specify)  |   |  | wn, State)   |  |  |  |  |  |
| Division of Vital Rector to the Hospital or Attending Physician: The lawfin 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, page ledical Certification: To Be Confedical Certification: To Be Confedical Certification:   | 29a Certifier  | knowledge, death occurred at the        | e time, date and place, and due to the   | cause(s) and manner as state<br>date and place, and due to the | ed.<br>e cause(s)                              |  |  |  |  |
| To the Ho within 24 To the Fu completel  | and manner stated.  29b. Signature and title of certifier  |   | c. License number  | 29d. Date signed (Mor  |  |  |  |  |  |
| 10   | 11.1.11-11-1-  | Τ1 λ                                    | O.C.M.E. OCME  | May 3, 2012  |  |  |  |  |  |
| 15 t 8m  | 30. Name and address of person who completed came of de  | eath (Item 23a)                         |  | MD 04000   |  |  |  |  |  |
| 1  |  |   | . Baltimore Street, Baltimore  | , IVID 21223   |  |  |  |  |  |
| State<br>Registra  | 31. Date filed (Month, Day, Year)  32. Registrari  | s Signature                             |  |  |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14595 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 540 M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore City **Examiner** 4b. City, Town, or Location of Death HOSDHO in 9. Birthplace (State or Foreign Country) MD Date of Birth (Month, Day (Year) Jun 16, 1929 **Funeral** If Under 24 Hrs. 212.46.5279 82 Hours **Director** 1 🗆 M 2 🗶 F Usual Residence of Decede 28a-f show 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard **Ellicott City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8407 Horseshoe Road 21043 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give hours after Maryland 21215-0036 White 2 No 1 Yes Specify. 3 → Widowed 4 □ Divorced Completed Specify Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **homemaker** 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname မ Thurman Kinsler Sr. Florence Redmond traumatic 19a. Informant's Name/Relationship (Type, Print) o. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8320 Fall Chill Court Ellicott City, MD 21043 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Frank Acra, Jr. son other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State injury or Good Shepherd Cemetery May 05, 2012 Ellicott City, Maryland Donation 5 Other (Specify) 22. Name Stack Tunier and Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 e of Funeral Servi any the dise se, or complications that seed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failur | List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ♥No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available this certificate has prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No ျှ 1 Yes Other: 1 Inpatient ER/Outpatient 3 -4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 🗌 Yes Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 9b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 181 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nathews Simon 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7:30 pm Mussara Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Cit University of Man Shock Travena Ctr If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 47 216-51-5513 1 🗆 M 2 🗶 F Director Pakistan Sept 15 1964 Usual Residence of Dec "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Glen Burnie MD Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 201 Vernon Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc Completed by 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 white 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) domestic homemaker Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked of any injury or other traumatic even once. ပ Sairan B. Choudry Ghulam Ghous Choudry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mahmood Ahmed (spouse) 201 Vernon Ave., Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, MD 5-10-12 Lake View Memorial 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility  ${ t Haight} \; { t Funeral} \; { t Home} \; { t \& } \; { t Chapel}$ ▶ Parge Haight Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph\_sician/ Scharachnoid disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examiner Due to for as a consoquence of g physician and as the burial-transi Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy ίο in the past 12 months? 1 ☐ Yes 2 🗷 No Pregnant at time of death 1 Yes 2 2 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page death? 2 N N 1 Yes 2 No this certificate Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X No ပ 1 Yes 1 Inpatient 2 ... ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After of completely filled in by the funer work? 1 X Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) PZ4432 06 5105 M.D. 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

de

9

Greene

5-12-15 'Beltimere, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Anne Brazel 03:04 OS 03 2012 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of Maryland University Baltimore MD Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours 545-25-0184 69 1 🗆 M 2 🗓 F **Director** 1942 England Yrs Oct. 19 or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD **Brookeville** Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 20883 USA 21601 Gentry Lane death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Decedent Armed Forces?

1 Yes 2 No er than "natural", or ite the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: white Completed 3 Widowed 4 N Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meginee. Elementary/Secondary (0-12) 12 College (1-4 or 5+) fashion seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Barnes Winnefred Kitten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Stephen Brazell (son) 4307 Groveland Ave., Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, Marriottsville, MD Crest Lawn Memorial 5-9-12 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licensee tredust thispland P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Acute Myelogenous unknum disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-tran attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 💆 No Month Day Year Pregnant at time of death signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an s certificate has b director, page 2 s performed Yes 2 X No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes မ 1 ื Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After 1 🔀 Natural 5  $\square$  Pending within 24 hours af er death. To the Funeral Director A completely filled in by th. fu 1 Yes 2 No Investigation Accident 6 ☐ Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD 05/03 2012 P24327

5√

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Mon

22 South Greene Street, Baltimore, MD 21210

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rochma

9

MAY 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 13:49 M Physician/ Month Mail Medical Cleo Grace Butler 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Upper Chesapeake Hospital</u> Maryland Harford 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 1 □ M 2 🏋 F 215-34-1035 74 11/03/1937 Maryland 28a-f show 10a. State at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Tes 2 X No MD Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2831 Harford Road U.S.A. 21047 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. or þ 1 Never Married 2 Married Yes Sive 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced Specify: Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Own Home Homemaker Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Fred Travis Kelley Genevieve Alice Warnicke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Clifford (daughter) 8817 Littlewood Road - Parkville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Joseph Church Cemi, 05/08/2012 | Baltimore, Maryland re of Funeral Service Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ orebra disease or condition resulting in death) 1 dece 4 Medical Due to (or as a consequence of) Examiner Sequentially list conditions. in any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or): Examir that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Vear Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? Vital 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 2 No 유 1 Yes 1 Doatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death of Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending Division 1 Tes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. Certifying Nurse Practitioner: To the best of my knowledge ideaths irred at the time, data and place, and due to the causes(s) and marrier as state D0053568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lesapea MOMPSON 32. Registrar's Signa State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First.: Middle, Lakt) 2. Date of Deat 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center N/A **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 7,1958 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕅 F Yrs 214-54-6703 54 Director Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits show Examiner must be notified et Director 1 X Yes 2 □ No MD N/A 28a-f Baltimore City 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ŏ 3808 Birchview Road 21206 Items 23a United States Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White 'natural", Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) than College (1-4 or 5+) 12 Years Accounts Payable Clerk Bakery Industry 7 is marked other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental I Robert H. Brundick, III Phoebe A. Umberger ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any injury or other trau Mrs. Phoebe A. Brundick (Mother) 7918 Deilwood Road Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 5/4/2012 Baltimore, Maryland 21. Signature of Furreral Service Lierinsee Michael Neiser 2 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 10hu 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Medical Due to (or as a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burlal-transit that initiated events The law requires that the death certificate be execu resulting in death) Last Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy director, page 2 should be detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 🗌 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has perforn 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be mer? Hospital: 1 Inpatient Other: 4 Nursing Home Yes 2 □ No 2 ER/Outpatient 3 🗌 DOA ပ 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) filled in by the funeral er of Death 28c. Injury at Work? Time of Certification: 28d. Describe how injury occurred Director: After Natural 5 Pending investigation Injury 1 Yes 2 No Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated. 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001 11595

State Registrar 4940 Eastern Avenue, Baltimore, MD, 21224

ompleted cause of death

Please Type on Print in Black Indelible Ink2 Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Katharine Bland 2. Date of Death Monto. Physician/ Medical stre&t and number Examiner 19 YA 62 S OWK Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 12-28-35 Country) 215-40-5724 76 Director MD 1 🗆 M 2 🔀 F 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Baltimore Catonsville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 21228 USA 1525 N. Rolling Road items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. þ 1 X Never Married 2 Married ō Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give "natural", Specify: Caucasian 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Social Security Admin. Mail Room <u>12th Grade</u> NA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည F. Bland Katharine Richard Bland, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 10 N. Calvert Street Suite #200 Baltimore, MD 21202 J. Michael Holloway-Guardian altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place
Metro Crematory 1 Burial 2 X Cremation 3 Removal from State 05-09-12 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause or Onset and Death Immediate Cause (Final Ph\_sician/ OU disease or condition resulting in death) Medical nce of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 this certificate has perform 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA □ Nursing Home 5 □ Residence 6 □ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: Natural 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After it (Month, Day, Year) 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ed (Month, Day, Year) 2012 mpleted cause of death (Item 23a) (Type, nomas 31. Date filed (Month, Day, Year, MAY 0 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-03484 State of Maryland / Department of Health and Mental Hygiene 2012 Abraham Barnett Certificate of Death 1- For State Registrar 2. Date of Death Time of Death 's Name (First, Middle,Last) Physician/ Month Day May 5, 2012 1519 hrs **Medical Examiner** nam 4b, City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Greenbelt 7678 Mandan Road 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY) If Linder 1 Year If Linder 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 576-41-6718 Country) Korea Director 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Ellicott 1 Yes 2 No MD s 23a or 28a-f show e notified at once. Howard permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygicine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 21043 5208 Hvenue 14 Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-11 Marital Status White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 orean 1 Yes American Yes 2 No specify: 4 Divorced If Yas, Give Year 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 12th 17. Father's Name (First, Middle, award long we and Number or Radioute Number, City or Town, State, Zip Code)
Wenue, Ellicoff City, MD 216 (Stre 5208 font 21042 (Futher 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 1 W Burial 2 Cremation 3 4 Donation 5 Other Specify Signature of Funeral Service Licen Baltimore Natil Pile (21229) 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death aNarcotic (morphine) Intoxication and cocaine use Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cau (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) g physician and the burial - trans Physician/Medical AMENDED23a, 27, 28a-f, per me, g927 5-10-12 sm **X** UNPENDED Box 68760, 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year 1 Live birth Fetal death 2 After this certificate has been signed by the attending funeral director, page 2 should be detached for use as it past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that t within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detac 1 Yes 2 V No 3 Probably 4 Unknown <u>۾</u> Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27, Manner of Death 1 Natural 1 Yes 2 X No unknown Division Pending fd 5-5-12 fd 3:00 pm Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7678 Mandan Rd. Greenbelt, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found in townhouse/rowhouse 6 X Could not be Suicide 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 6, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Donna M. Vincenti, MD Assistant Medical Examiner State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|   |                | 4             | ForState   | State   | of Maryland   |                                       |   |                            |               | and M           | lental Hy                                      |                         | 201                         | 2  | 1 4                                  | 602          |
|---|----------------|---------------|--|---|---|---------------------------------------|---|----------------------------|---------------|-----------------|--|-------------------------|-----------------------------|--|--------------------------------------|--------------|
|   |                | 1             | Registrar  . Decedent's Name (First, Middle  | Last)   |   | Cer                                   | tificate  | 010                        | eam           |                 | 2. Date of De                                  | Reg. No.                | 201                         |  | Time of E                            |              |
| Physic  | cian/<br>dical | 1             | Charles L. Br  |   |   |                                       |   |                            |               |                 | Month<br>May                                   | 3, 2012 8:45 A M        |                             |  |                                      |              |
| Exan  |                |               | a. Facility Name (if not institution,  |   | nber)   |                                       | 4b. City,   | lown, or                   | Location o    | of Death        |  |                         | County of De                |  |                                      |              |
| <i></i>   |                |               | Glen Burnie Health  Social Security Number   |   |   |                                       | Glen Burnie ) If Under 1 Year   If Under 24 Hrs.  |                            |               |                 | Anne Arunde  8. Date of Birth 9. Birthplace (S |                         |                             |  |                                      | Foreign      |
| Funer<br>Direct   | _              | - 1           | 235-58-2854  | 6. Sex<br>1 🔀 M 2 □ F   | 7. Age (In yrs. Ia:                                       |                                       | Months  | Days                       | Hours         | Min.            | (Month, Da                                     | ıy, Year)               | C                           | 9. Birthplace (State or Foreign Country) |                                      |              |
|   | _              |               | Usual Residence of Decedent  |   |   |                                       | .,,   |                            |               |                 | May 30   | y 30, 1941   West Vi    |                             |  |                                      |              |
| ryland<br>-f sho  | Director       | 5   1<br>5    | 0a. State 10b. County  |   | 10c. City   | , Town or Loc                         |   |                            |               |                 |  |                         |                             |  | nside City                           |              |
| he Ma<br>or 28a<br>or otif  | غ ا            |               | Maryland Anne  Oe. Street and Number   | <u>Arundel</u>  |   | G                                     | ambr i<br>10f. Zip  |                            |               |                 |  | 10g. Citiz              | zen of What 0               |  |                                      |              |
| with t  | 2              | Luliera       | 2321 Silver Way  | 7   |   |                                       |   | 210                        | 54            |                 |  | Un                      | United States               |  |                                      |              |
| death<br>items<br>ner m   | 1              |               | 1. Marital Status  | 12. Was Dece  | edent Ever in U.S.<br>prces?                              | . 13. V                               | Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc. |                            |               |                 |  | - 1                     | 4. Race - An<br>Black, Wh   |  | dian,                                |              |
| after after samil, or xamil   | 1              | S C           | 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced                                     | 1   | ☐ Yes   | No                                    | Specify:  |                            |               | 5               | Specify:                                       | Whit                    | :e                          |  |                                      |              |
| in 72 hours after<br>e.<br>nan "natural", o<br>Medical Exam   | 1              | Completed     | 15. Deceder  | nt's Education  |   | 16a. Deced                            | lent's Usua   | I Оссира                   | ation         | A = 6 14 15 mls | ina  | 16b. Kir                | nd of Busines               | s/Industr                                | У                                    |              |
| ZIS<br>lin 72<br>le.<br>han "l  |                |               | (Specify only night  | st grade completed<br>College (1                                |   | life. D                               | kind of wor<br>O NOT use  | retired)                   |               | t of work       | ing  |                         | - 1.                        |  |                                      | Ì            |
| d with<br>hygien<br>ther t  |                | 3) -          | 8<br>17. Father's Name (First, Middle, L   | act)  |   | 1                                     | ruck  | Dri                        |               | er's Nam        | e (First, Middle                               |                         | Trucki                      | ng                                       |                                      |              |
| yland Id be filed Mental Hy arked ott   | 1              | o l           | Jack Bryant  |   |   |                                       |   |                            |               |                 | Cruick   |                         |                             |  |                                      |              |
| <b>Baltimore,</b> Maryland ZIZIO-0000 permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygene. Important if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner. |                | ŧ             | 19a. Informant's Name/Relations  | nip (Type, Print)   |   | 19b. Mailir                           | ng Address  | (Street a                  |               |                 | al Route Numb                                  |                         |                             | Zip Code                                 | )                                    |              |
| e, M<br>and 2 s<br>Health<br>tem 27   |                |               | Mary J. Campbel  | 1/Caregi  |   |                                       |   |                            | Isla          |                 | oad, Ed  |                         |                             |  |                                      | 21037        |
| DOFE<br>ge 1a<br>it of H<br>if ite<br>or oth  |                | 1             | 20a. Method of Disposition 1  Burial 2  Cremation 4  Donation 5  Other (\$                 | 3 Removal from  | n State 20b. Pl   | lace of Dispo<br>emetery, crer<br>Wes | nsition (Nam<br>natory or o   | ne of<br>ther plac<br>inde | e)            |                 | Date<br>9,<br>2                                |                         | cation - City               |  |                                      |              |
| Saltimor permit. Page 1 Department of Important: If it any injury or o  | oi l           | +             | 4 ☐ Donation 5 ☐ Other (S<br>21. Signature of Funeral Service I                            |   | 7   | 7 C                                   | Name ar   | ory<br>d Addres            | s of Facili   |                 |  |                         | ton, M                      |  |                                      |              |
| and de  | ouc            | 1             | PARIES   |   | M013  | 86 I                                  | onald<br>411  | lson<br>Innaj              | Fune<br>polis | ral<br>Roa      | Home &   | Crem                    | atory<br>Maryl              | P.A<br>and                               | 2111                                 | 3            |
| VALUE OF STREET   | 22.2           |               | 23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final | complications that<br>only one cause on e                       | caused the death<br>dch line.                             | n. Do not ente                        | er the mod  | e of dyin                  | g, such as    | cardiac         | or respiratory a                               | rrest,                  |                             | Inte                                     | proximate<br>erval Betw<br>set and D | /een         |
| Medic   | _              | Ì             | disease or condition resulting in death)   |   | arcinoma<br>(or as a consequ                              |                                       | e Re  | tum                        | _             |                 |  |                         |                             |  |                                      |              |
| Examin  |                |               | Sequentially list conditions,  | b. ——   |   |                                       |   |                            |               |                 |  |                         |                             | _  |                                      |              |
| d<br>sit  |                | E L           | if any, leading to immediate  Due to (or as a consequence of):  cause. Enter Underlying    |   |   |                                       |   |                            |               |                 |  |                         |                             |  |                                      |              |
| executed<br>an and<br>rial-transi   |                | Examiner      | Cause (Disease or injury<br>that initiated events<br>resulting in death) Last              | c. Due to   | (or as a consequ  | ience of):                            |   |                            |               |                 |  |                         |                             |  |                                      |              |
| Pu ici  |                | <u>ea</u>     |  | d   |   |                                       |   |                            |               |                 |  |                         |                             |  |                                      |              |
| , P.O. Box 68/60.  So that the death certificate I gened by the attending phys be detached for use as the   |                | Physician/Med | IF FEMALE:   | 1   |   |                                       | _   |                            |               |                 |  | Т                       |                             |  |                                      |              |
| OX 6<br>th cer<br>thendi  |                | ian           | 23b. Was decedent pregnant in the past 12 months?  | 1 Live  | utcome of pregna<br>e Birth 2  Feta<br>anant at time of c | I death 3                             | Ectopic Other (s)   |                            | су            |                 |  |                         | 23d. Date of<br>Month       | delivery<br>Day                          | / Y                                  | ear ear      |
| he death or y the atter y the atter ached for u   |                | nysi(         | 1 Yes 2 No<br>9 Unknown  | g 🗆 Uni   |   |                                       |   |                            |               |                 |  |                         |                             |  |                                      |              |
| Hat the property of the deta  | 1              | by P          | Part II. Other significant conditi   | ons contributing to   | death but not res   | ulting in the                         | underlying  | cause giv                  | ven in Par    | t I.            |  |                         | se contribute               |  |                                      |              |
| 'ds,<br>equires   |                | ed            | Dementia   |   |   |                                       |   |                            |               |                 |  |                         | X No 3                      |  |                                      |              |
| law rehas be  |                | Completed by  |  |   |   |                                       |   |                            |               |                 | 24a. Wa<br>aut<br>per                          | s an<br>opsy<br>formed? | 24b. Were<br>prior<br>death | to compl                                 | tindings a<br>etion of ca            | ause of      |
| I Re<br>n: The<br>fficate<br>or, pag  | (              |               | 25. Was case referred to medical   | 1   |   |                                       |   | 26 P                       | lace of De    | ath (Chec       | 1 \(\sum \) Yes                                | 2 N No                  | 1 🗆                         | Yes 2L                                   | □ No                                 |              |
| Vita ysicia ysicia is cert direct   | 1              | To Be         | examiner?<br>1 ☐ Yes 2 🔀 No  | Hospital:   | Inpatient 2 🗆   | ER/Outpatie                           | nt 3 🗆 D  | Oth                        |               |                 | ome 5 🗆 Res                                    | sidence 6               | Other (Sp                   | ecify)                                   |                                      |              |
| ng Ph<br>fter th<br>uneral  |                |               | 27. Manner of Death 1 ☑ Natural 5 ☐ Pendi  | // // -   | e of injury<br>onth, Day, Year)                           | 28b. Time o<br>injury                 |   | 28c. Injur<br>work         | έ?            | _               | 28d. Describe                                  | how injury              | y occurred                  |  |                                      |              |
| Sion<br>ttendi<br>death.<br>stor: A   |                | Certificate:  | 2 Accident Invest  | igation<br>I not be   | ce of Injury - At ho                                      | me, farm, st                          | M<br>reet, factor   |                            | Yes 2         | _l No           | 28f. Location                                  | (Street and             | d Number or                 | Rural Ro                                 | ute Numb                             | er.          |
| Division of Vital Records, cal or Attending Physician: The law requires is after death.  al Director, After this certificate has been signed in you the funeral director, page 2 should it.   |                |               | 4 L Homicide determ  | nined buil  | ding, etc. (Specify                                       | )                                     |   | ,,                         |               |                 |  | own, State)             |                             |  |                                      |              |
| Division of Vital Records, P.O. I To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by tf competely filled in by the funeral director, page 2 should be detach.  |                | Medical       | (Check 2 Medical   | g Physician: To the<br>Examiner: On the b<br>g Nurse Practition | asis of examination                                       | n and/or inve                         | stigation, in   | my opini                   | on, death     | occurred :      | at the time, date                              | and place               | , and due to t              | ne cause(                                | s) and ma                            | nner stated. |
| To the within To the Comple   |                | Σ             | only one) 3 L Certifyin<br>29b. Signature and thie of certifyin                            | g Nurse Practition  | er: to the best of t                                      | Thy Knowledge                         |   |                            | e number      | ate and p       | lace, and dec t                                |                         | te signed (Mo               |  |                                      |              |
|   |                |               | D 24/11  | l   |   |                                       |   | D38                        | 3958          |                 |  | Ma                      | y 4, 2                      | 012                                      |                                      |              |
|   |                |               | 30. Name and address opersor Daljeet Sidhu,  | who completed ca  |   |                                       |   | uth,                       | Gle           | n Bu            | rnie, N  | aryl:                   | and 21                      | 061                                      |                                      |              |
|   | State          |               | 31. Date filed (Month, Day, Year)  | 37  | Registrar's Signa   | ture                                  |   |                            |               |                 |  |                         |                             |  |                                      |              |
| Reg   | เรแช           | r             | MAY 0 9  | CUIZ CE   | our p   | 1. 19                                 |   |                            |               |                 |  |                         |                             |  |                                      |              |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-03424 State of Maryland / Department of Health and Mental Hygiene Melvin Dewitt Bair 2012 14603 Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 1327 hrs May 3, 2012 Medical Examiner Melvin D. Bair Sr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Carroll Westminster 1509 Chris Lane 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days Months Hours 10-12-1921 Country) MD 90 Director 214-18-0418 1 X M 2 F Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No 23a or 28a-f show MD Carroll Westminster it Pages I and 2 should be filed within 72 hours after death with the Maryland urtnernt of Health and Mental Hygiene.
urtnernt of Health and Mental Hygiene.
"matural", or item 27 is marked other than "matural", or items 23a or 28a-f sho ry or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1509 Chris Lane 21158 USA 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or Nouneral 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 Married 1 Never Married <sub>Specify:</sub> white If Yes, Give Yaer 1 Yes 2 No specify: 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) ć 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Construction Builder 10 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Howard Lee Bair Sr. Mamie Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Mark Bayline-step son 1509 Chris Lane, Westminster, MD 21158 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State South Carroll Crem 5/9/12 Sykesville, MD 4 Donation 5 Other Specify 22. Name and Address of FacilityFletcher Funeral Home Signatury of Funeral Service Licensee 254 E. Main St., Westminster, MD 21157 ullu Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** Between Onset and failure. List only one cause on each line. Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDED e attending physician : for use as the burial -UNPENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown certificate has been signed by the rector, page 2 should be detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown Š Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of eutopsy performed' ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: Scene DOA 2 ER/Outpatient 3 1 Yes ۴ 28a. Date of Injury (Month, Day,Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification 1 V Natural 1 Yes 2 No 5 Pending Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifier May 4, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD. 31. Date filed (Month, State Registrar ORIGINAL

DHMH 17 Rev 1/2001

OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ BOOKEY 1111.5 0535 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Mercy Medical Center Himore alt Ba more 8. Date of Birth (Month, Day, Year) Nov\_26,1 5. Social Security Number Sex If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday g. Birthplace (State or Foreign **Funeral** Min. Months Days Hours Country) **Director** 214-56-7230 61 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5702 Sefton Ave. Funeral 21214 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces Black, White, etc. or 1 Never Married 2 X Married ģ 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) 9th <u> Machine Operator</u> Water Front Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I ပ James Katie Craddock and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Trudy Booker (wife) 5702 Sefton Ave. Balto, Md. Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery May 11,2012 Balto, Md. re of Eun Calvin B. Scruggs Funeral Home St Preston Balto, Md. 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ metastati Liver cancer disease or condition Medical resulting in death) ue to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Either United lying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE nse yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death Other (specify) 1 Yes 2 Unknown 2 🗌 No g Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hepatitis C 1 Yes 2 No 3 Probably 4- Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 9 Hospital or Attending Physician: The law 124 hours after death.
9 Funeral Director: After this certificate has b. performed' 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ☐ No မ 1 Inpatient 2 X ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Paca St. Baltimore 110 Romaniuk m.D Ictoria 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene statement of Health and Mental Hygiene me, 9228,06/11/2012dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Raymond Michael 2012Medical May 6 4:45 P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Cromwell Baltimore Parkville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) January 2, 1952 **Funeral** 9. Birthplace (State or Foreign Days Hours **Director** 218-68-6843 Maryland 1 X M 2 🗆 F 60 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Baltimore Parkville 1 Yes 2 X No 10e. Street and Number ò items 23a or ner must be n 10g. Citizen of What Country? Funeral 8810 Walther Blvd. # 3127 21234 USA death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. n "natural", or iten ledical Examiner n 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married and 2 should be filed within 72 hours after Health and Mental Hygiene. tem 27 is marked other than "natural", on other traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance ARC of Baltimore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ A. Raymond Bevans, Jr. F. Claire Linz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i Mrs. F. Claire Bevans (Mother) 8810 Walther Blvd. Parkville, Maryland 21234 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Department of H Important: If ite any injury or oth 20c. Location - City or Town, State Page 1 Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 75 Other (Specify) St. John Long Green Cem. 5/10/2012 Hydes, Maryland permit. 21. Signatur 22. Name and Address of Facility 21204 Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. Part 1. Enter the disea shock, or heart failure. te, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. **Atherosclerotic Cardiovascular Disease** Approximate Interval Between Immediate Cause (Final Physician/ disease or condition NOENTA Medical resulting in death) Due to (or as a consequence of) **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence on MEDICAL EXAMINER burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical the death certificate be 240 Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Month Day Year Yes 2 No detached 1 Yes 2 9 Unknown 9 Unknown β Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Funeral Director, After this certificate has been signer.

To the Funeral Director, After this certificate so been signer. þ Quadriplegia due to Cervical Stenosis Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 1 No Division of Vital 25. Was case referred to medical or Attending Physician; Be 26. Place of Death (Check only one) examiner? ပ Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D0068454 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 UNG 8710 EMGE RD PARKVILLE, MD 21234 AME 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

MAY 0 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 07 Physician/ 9:05 AM May Veronica Jean Bean Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 309 Custer Court Lusby Calvert Birthplace (State or Foreign Country)
 New Jersey If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 🛛 F Months Hours 11/30/1944Director 220-42-1204 67 Usual Residence of Decedent show 10d, Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 X Yes 2 No Calvert MD Lusby 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 20657 U.S.A. 309 Custer Court Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: If Yes Give 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cashier Retail Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gertrude Brehenny Ernest Theodore Bean Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Andes / Daughter 309 Custer Court, Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 05/09/2012 Hanover, Maryland 4 X Donation 5 Other (Specify) 21, Signature Funeral Servic Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Medical resulting in death) Due to (or s a consi quence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for ea a consequence of: Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician a should be detached for use as the burialby Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ျာ 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 5 Pending 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Rractioner: To the Dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗍 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person

NAY 0 9 2012

(Month, Day, Year,

238 Merrimac

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 2:10 P Antoinette B. Brasso May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Columbia Howard Brighton Gardens - Columbia Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Hours (Month, Day, Year) **Director** 579-10-3967 1 M 2 X June 27, 1919 92 Washington, D.C. 28a-f show 10b. County death with the Maryland 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits be notified 1 Yes 2X No Columbia Maryland Howard 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21044 6516 Waving Tree Court United States items ? 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinonce. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed 3 X Widowed 4 Divorced Specify Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Veteran's Administration Forms Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Julius Caesar Chlopicki Rosalie E. Stracilo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6516 Waving Tree Court, Columbia, Maryland 21044 William B. Brasso / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cerMetery Crematory or other place) Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) May 7, 2012 Bethesda, Maryland 21. Signature of Funeral Service Licenses Robert A. Fumphrey Funeral Home/Bethesda-Chevy Chase, Inc. -M013607557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Congestive Heart Failure Medical Due to (or as a consequence of) Examiner Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to lor as a consuluence of Exami Cause (Disease or injury Diabetes Mellitus that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as the attending IF FEMALE use a outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Live Birth 2 Fetal death detached for I in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown Month Day Pregnant at time of death g Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director; After this certificate h performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted 1 🗌 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 🔲 Yes Investigation 2 🗌 No the ☐ Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pletely filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 deficiency of the cause of only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) Richard Kolodrubetz, M.D. 8186 Lark Brown Road, Elkridge, Maryland 21075

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)
NAY 0 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Year May 6 Bescher Marie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medstar Montgomery Medical Center 01ney Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 121-24-6743 **Director** 1 □ M 2 🛛 F 82 April 2, 1930 New York Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10a. State must be notified at 10c. City. Town or Location Director 1 Yes 2 X No Maryland Montgomery Germantown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 13400 Ansel Terrace, 20874 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black White, etc. 0 þ 1 Never Married 2 Married 2 **X** No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify "natural", White Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Admin. 12 Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Angelo Nolasco Bagarella Giovanna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1. any injury or other \*\*\* 406 Kentlands Blvd. #303, Gaithersburg, Maryland 20878 Arthur F. Bescher, Jr. /son 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. May 9, 2012 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Funeral M01305 Part 1. Error the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, otherst failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ SEPTIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PNEUMONIA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examir I KACHEOSTONY The law requires that the death certificate be executed and that initiated events resulting in death) Last burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Day Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) or Attending Physician: Be examiner? Hospital Other: 2 No 1 Tes ER/Outpatient 3 DOA ပ္ 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After + Certificate: (Month, Day, Year) iniury work? 1 Yes 2 No 1 Natural To the most after death.

Within 24 hours after death.

To the Funeral Director. Aft 5 Pendina 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

· or

Registrar

MEDSTAR

MONTGONERY

MEDICAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

ALUNFARA

MAY 0 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 2012 Fedora L. Baldwin 8:30 A MMedical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Tate House - Hospice Of The Chesapeake Anne Arundel Linthicum 8. Date of Birth (Month, Day, Year) 12/11/1964 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 □ F Maryland 217-86-1448 Director Usual Residence of Deced 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Medical Examiner must be notified at Director 1X Yes 2 □ No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 7611 Woodpark Lane, Apt. 102 21046 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 X Never Married 2 ☐ Married 1 Yes : Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Did Not Work 9 N/A Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Baldwin Aurelia Ferraro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jesse Gegenheimer / Son 5406 Ellerbie St, Lanham, MD 20706 20a. Method of Disposition
1 

Burial 2 

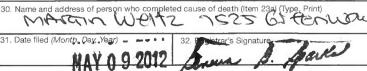
Cremation 3 

Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of I Important: If ite any injury or ot once. Chesapeake Crematory 5/4/2012 4 Donation 5 Other (Specify) Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Breast Cancer Physician/ ハナラマアラア disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner il any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Pregnant at time of death been signed by the s should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autonsy death? ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 28b. Time of Certificate: Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Natural Accident injury 5 Pending 1 🗌 Yes 2 🗌 No Investigation 24 hours after deatl Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

6V

31. Date filed (Month, Day, Year) -



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Month 02° 2012 8:40 Рм Genevieve Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Senator Bob Hooper House Forest Hill 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Buffalo **Funeral** 114-16-0123 1 □ M 2 🏅 F 86 **Director** April 25, 1926 New York Usual Residence of Dece Show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Funeral Director Medical Examiner must be notified at 23a or 28a-Maryland 1 Yes 2 X No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1802 Rollins Court 21014 U.S.A. or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes permit. Page 1 and 2 should be filed within 72 hours after 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural" 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done life, DO NOT use retired) during most of working Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Teacher - Home Economics Education Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Chiavaro Luisa Piccoli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tratonce. 1802 Rollins Court, Bel Air, Maryland, 21014 Mrs. Suzanne Maras - Daughter Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 05, ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State Evans Funeral (hape) Bel Air Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — Bel Air
3 Newport Drive, Forest Hill, Maryland 21050 of Funeral Service Licensee Jeffrey R. Testerman (M01543) Pint, End the disease, or complications that caused the death, slock, or cart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury requires that the death certificate be executed that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) ☐ Live Birth 2 ☐ Fetal 300 ☐ Pregnant at time of death ☐ Unknown Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ate has been signed by the atte page 2 should be detached for Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Il or Attending Physician: The after death.

Director; After this certificate h 1 🗌 Yes Yes by the funeral director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) X Other HOSPICE HOUSE 1 🗌 Yes Other 4 Nursing Home 5 Residence 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 1 \( \subseteq \text{Yes} 5 Pending 2 🗌 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and npleted cause of death (Item 23a) (Type, Print)

NS 230 DUCANCY

32. Registrar's Spread State Registrar

| 12-03511   |        |
|------------|--------|
| Sherry Ann | Baquol |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Sherry Ann Baquo   | herry Ann Baquol State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death  Peg No. 2012 1  |  |               |                         |                         |                                       |  |                         |                     |                  | 461       |                          |              |                              |                        |
|--|---|--|---------------|-------------------------|-------------------------|---------------------------------------|--|-------------------------|---------------------|------------------|-----------|--------------------------|--------------|------------------------------|------------------------|
| Physician  | 1/  | Registrar  1. Decedent's Name (First, M  |               |                         |                         |                                       |  |                         |                     | 2. Date of De    | Day       | Year                     | 3.           | Time of De                   |                        |
| Medical Examine  |   | S}<br>4a. Facility Name (if not instit   | erry          | Ann                     |                         | ruol                                  | 4b. City, Town,                          | or Location             | of Death            | May 6, 20        | 012       | . County of D            | L            | 2034 hrs                     | S                      |
|  |   | 14815 Jarrettsville  | -             |                         |                         |                                       | Monkton                                  |                         |                     |                  |           | Baltimore                |              |                              |                        |
| Funeral<br>Director  |   | 5. Social Security Number  | 6. Sex        |                         | 7. Age (In yrs          | . last birthday)                      |  | ear If Und<br>ays Hours | er 24Hrs.<br>s Min. | 8. Date of B     | 31        | 1060 F                   | oreian       |                              |                        |
|  | ŀ   | 215-50-5713 Usual Residence of Deceden   |               | XXF                     | 5 1                     | Yrs                                   | 5.                                       |                         |                     | ala              | 1 30      | ,1900                    | Country      | Mary                         | land                   |
| w any  |   | 10a. State 10b. Cour   | ,             |                         | 10c. Ci                 | ty, Town or Local                     |  |                         |                     |                  |           |                          |              | d. Inside C                  |                        |
| a-f show   | [   | Maryland Ba  | ltim          | ore                     | <u> </u>                |                                       | MOT<br>10f. Zip Code                     | kton                    |                     |                  | 10a Citiz | zen of What              |              | Yes 2                        | 2 <u>X</u> <u>X</u> No |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Re Completed by Firnaral Director | 2   | 15028 Mar  | or            | Road                    |                         |                                       |  | 1111                    |                     |                  | _         | ed State                 |              |                              | æ                      |
| er death with , or items 23.   | le la   | 11. Marital Status  1 Never Married 2  | 1<br>Married  | 2. Was Dece<br>Armed Fo | edent Ever in<br>orces? |                                       | as Decedent of<br>es, specify Cub        |                         |                     |                  | 0-        | 14. Race - A<br>White, e |              | Indian, Bla                  | ick,                   |
| fter dea   |   |  | 1 Divorced    | l Yes<br>Yes, Give Year | 2√X №                   | 1                                     | Yes 2x                                   | No specify:             | :                   |                  |           | Specify: W               | Mit          | е                            |                        |
| hours aft uatural?   | 0 0   | 15. Decedent's Education (\$   | pecify only l |                         |                         |                                       | nt's Usual Occu                          |                         |                     |                  | 16b. K    | (ind of Busin            | ess/Indus    | stry                         |                        |
| 5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan  | Diec  | Elementary/Secondary (0-1  | 2)            | College (1-             | -4 or 5+)               | Senio                                 | Sales A                                  | <b>Issociat</b>         | æ                   |                  | Fi        | re &                     | Ice          | , In                         | ıc.                    |
| 21215-0036 Muld be filed within 7 Montal Hygiene. marked other than c event, the Medica  |   | 17. Father's Name (First, Mide   | lle, Last)    |                         |                         |                                       | ing/1000                                 |                         | -                   | First, Middle,   | Maiden    | Surname)                 |              |                              |                        |
| 2121<br>sould be fil<br>d Mental Is<br>is marked<br>tic event,   | 9 L   | Wa<br>19a. Informant's Name/Relatio  |               | Johr                    | nston                   | 19b Mailin                            | g Address (St                            | reet and Nur            |                     | rtha             |           |                          | State 7in    | Code)                        |                        |
| MD 2 should and 1 is a 2 should and 1 is a 2 is a summatic   | -   | Ronald L. Bac  |               |                         | sband                   |                                       | Merry                                    |                         |                     |                  |           |                          |              |                              | 131                    |
| or Heal  | 1   | 20a. Method of Disposition  1 X X Burial 2 Crema   | ion 3         | Removal fro             | m State                 | . Place of Dispos<br>crematory or ot  | her place)                               | cemetery,               |                     | Date             |           | ocation - Cit            | •            |                              |                        |
| Baltimore,<br>permit. Pages I a<br>Department of He<br>Important: If ite   | II.   | 4 Donation 5 Other 21 Signature of Funeral Serv  | Specify:      |                         |                         | Dulaney<br>Memorial                   | Garder                                   | ns of Eagilit           | _                   | 11,2012          |           | monium,                  | _            |                              | -                      |
| Bal<br>permi<br>Depa<br>Injur  |   | Stories of Pulleran Serv   |               | mah                     | 1                       |                                       | lame and Addre<br>vans Fune<br>5924 York |                         |                     |                  |           |                          | s - M        | íbnktar                      | ו                      |
| Physician<br>/Medical  |   | 23a. Part I. Enter the disease, failure. List only one cau   |               |                         | used the dea            |                                       |  |                         |                     |                  |           |                          |              | pproximate<br>etween Or      |                        |
| Examiner   |   | Immediate Cause (Final disea<br>or condition resulting in death  |               |                         | Le Inju                 |                                       |  | -                       |                     |                  |           |                          | $\perp$      | Deat                         | h                      |
|  |   | Sequentially list conditions,  | b             |                         |                         |                                       |  |                         |                     |                  |           |                          |              |                              |                        |
| mine.  |   | if any, leading to immediate<br>cause. Enter Underlying Cau<br>(Disease or injury that initiate  | se c          | ·                       | consequence             |                                       |  |                         |                     |                  |           |                          |              |                              |                        |
| nsit ed d  |   | events resulting in death) La  |               | e to (or as a           | consequence             | of):                                  |  |                         |                     |                  |           |                          |              |                              |                        |
| 0, control of the executed sician and burial - trans   | 200   | <b>▼</b> UNPENDED  | X A           | MENDED#                 | 23a,27<br>8perFH.0      | <b>28a-f</b><br>927 <b>,</b> 5/10/    | oer me, g<br>2012.WS                     | 3927 5                  | -18-                | 12 sm            |           |                          |              |                              |                        |
| 6876C<br>ertificate l<br>ding phys<br>e as the by  | 2   | F FEMALE:<br>3b. Was decedent pregnant in  |               |                         | utcome of pre           | gnancy                                |  |                         | c pregnan           |                  |           | l. Date of del<br>Month  | ivery<br>Day | Y                            | ear                    |
| Box 6876( death certificate the attending physician/Me   |   | past 12 months?  1 Yes 2 ✓ No 9  | Jnknown ,     | 4 Pregna                | ant at time of o        | leath -                               | her (Specify)                            |                         |                     |                  |           |                          |              |                              |                        |
| P.O. Box<br>that the death<br>med by the atter<br>detached for u   |   | Part II. Other significant con   |               |                         |                         | resulting in the u                    | inderlying caus                          | given in Pa             | art I.              | 23e. Did t       | obacco u  | use contribut            | e to the c   | ause of de                   | eath?                  |
| Division of Vital Records, P.O. ral or attending Physician: The law requires that it is after death.  a) Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by P  |   |  |               |                         |                         |                                       |  |                         |                     | Name of the last |           | No 3                     | Probably     | 4 Un                         | known                  |
| Records, The law requirer ficate has been sig  |   |  |               |                         |                         |                                       |  |                         |                     | 24a. Was<br>auto |           |                          | to compl     | y findings a<br>letion of ca |                        |
| Vital Rec<br>yyician: The l<br>his certificate h<br>director, page   |   | 25. Was case referred to med   | cal           |                         |                         |                                       | 26 Pla                                   | ce of Death             | (Check or           | 1 Yes            |           |                          | Yes          | 2                            | No                     |
| Vital bysician this cert directo   |   | examiner? 1 ✓ Yes 2 No   | Hosp          | oital: 1 In             | npatient 2              | ER/Outpatient                         |  | low-                    |                     | Home 5           | Resider   | nce 6 🗸 C                | ther: Sce    | ene                          | 7                      |
| n of ding Ph.  After tl. funeral   |   | 27. Manner of Death 1 Natural 5 Pe   |               | 28a. Date of<br>(Month, | of Injury<br>Day,Year)  | 28b. Time of I                        |  | jury at Work            | . 14                | 28d. Describe    | how inju  | ry occurred              | Subj<br>ngle | ecţdi<br>vehi                | river<br>cle           |
| r Atten<br>or death<br>rector:<br>by the   | fd 5-6-12   fd 8:18 pm   1 res 2 x No   accident   1 restigation   1 restigation   2 x Accident   28e Place of Injury - At home, farm, street, factory, office building, etc.   28f   1 ccation (Street and Number of Rural Route Number of Rural |  |               |                         |                         |                                       |  |                         |                     |                  |           | per, City                |              |                              |                        |
| Div<br>pital or<br>ours aft<br>filled ir   | Suicide 6 Could not be determined (Specify) Roadway  Suicide 6 Could not be determined (Specify) Roadway  Suicide 6 Could not be determined (Specify) Roadway  CorTown, State) Jarrettsville Pike Monkton, MD.  |  |               |                         |                         |                                       |  |                         |                     |                  |           | ike                      |              |                              |                        |
| 8-5-8  | - 1   | 29a. Certifier 1 Certifying (Check only one) 2 Medical E   |               |                         |                         | dge, death occur<br>and/or investigat |  |                         |                     |                  |           |                          |              | ıse(s)                       |                        |
| To the H<br>within 24<br>To the Fr<br>completel  |   | 29b. Signature and title of cert   | an            | d manner sta            | ated.                   |                                       |  | nse number              |                     | Me               |           | ate signed               |              |                              |                        |
| (D)  |   | tamete Parkar  | 1, mi         | )                       |                         |                                       | 0.0                                      | .M.E.                   | PALLE               |                  | May       | 7, 2012                  |              |                              |                        |
| They !   |   | 30. Nome and address of pers<br>Pamela E. Southall,  |               | •                       |                         | •                                     | ) W. Baltimo                             | ore Street              | , Baltim            | ore, MD 2        | 1223      |                          |              |                              |                        |
| State  | e i   | Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  31. Date filed (Month, Day, Year)  32. Registrar's Signature |               |                         |                         |                                       |  |                         |                     |                  |           |                          |              |                              |                        |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ 5:00 AM RUTH R BIERER 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE 4001 OLD COURT ROAD, APT. BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Hours Min 0770671922 215-14-5443 89 Director MT Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😿 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 4001 OLD COURT ROAD, APT. 109 21208 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired)  $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12 \end{array}$ College (1-4 or 5+) OWNER LIQUOR STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ SAMUEL REISBERG ANNA SUMMERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau STEPHEN BIERER/SON 3000 STONE CLIFF DRIVE, #106, BALTIMORE, MD 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) BNAI ISRAEL CEMETERY :05/08/2012 BALTIMORE, MD 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ malignant weeks 10 m disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events and -tran Due to (or as a consequence of): resulting in death) Last burial physician the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Month Year Pregnant at time of death the Unknown 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Myelodysplasia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 2 No Yes 2 LIN 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No after death. Accident Investigation 6 Could not be within 24 hours after death

To the Funeral Director:

completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Rothschild

31. Date filed (Month, Day, Year,

4000

Old

Court

Swite 301,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL30° 2012 FREDA BAZENSKY 08:25 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE FUTURE CARE - OLD COURT RANDALLSTOWN Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 04/17/1920 Months Hours 1 🗆 M 2 🕱 F 218-03-0740 92 MD Director Usual Residence of Decedent shov 10a. State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sh notified a 1 Yes 2 No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or must be r Funeral 1450 BEDFORD AVENUE, #218 21208 USA items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ural", or iter Black, White, etc. þ 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE Completed 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CO-OWNER LIQUOR INDUSTRY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ MAXIMILIAN AUSLANDER BESSIE BECKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JERRY BAZENSKY / SON 123 CHESTNUT HILL LANE WEST REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State EMUNAH CONG. 4 Donation 5 Other (Specify) 05/02/2012 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Sign turn of Funeral Service License 8900 REISTERSTOWN ROAD PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition CARDIAC ARRHYTHMIA Medical resulting in death) Due to (or as a consequence of): Examiner COPD Sequentially list conditions. Examine if any, leading to immediate cause Enter U Janying Cause (Disease or iinjury Due to (or as a consequence of): led by the attending physician and detached for use as the burial-transit law requires that the death certificate be executed CAD that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? After this certificate 1 Yes 2 No Yes Hospital or Attending Physician: 24 hours after death.
 Funeral Director: After this certifical the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 XNo Other: 1 Yes 4 X Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatule and title of rtifie

State Registrar

DHMH 17 Rev 7/2009

5415 OLD COURT ROAD, SUITE 101, RANDALLSTOWN,

MD

rson who completed cause of death (Item 23a) (Type, Print)

KOFI OWLISU-ANTWI,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Roosevelt 2331 Brown 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A University of Maryland Medical Center 5. Social Security Number 417-32-3284 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours **Director** 1 🖾 M 2 🗆 F 84 12/29/1927 Alabama or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD N/A 1 XYes 2 No Baltimore 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 5039 The Alameda 21239 U.S.A. hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Black "natural", 3 X Widowed 4 Divorced Completed the Medical Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry General and Mental Hygiene.

is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Refractories 8th Grade Engineer Be filed 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Cassie Smith Sherman Brown Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print)Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Edith Brown Johnson 4907 The Alameda, Baltimore, MD 21239 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Garrison Forest 05/03/12 Owings Mills, eral Service Licensee oseph H. Brown Jr. Funeral Home PA 3140 N. Fulton Ave., Baltimore, MD21217 3140 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cervical Spine Ph sician/ Fracture disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DERIFICATION APPROVED BY WE DICKLE EXAMINE Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Examine Due to for as a consequence of, the burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 88 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown 9 Unknown s been signed by the should be detach Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗌 No Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27 Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 X Accident 5 Pending work? 1 ☐ Yes 2 No after death. 26/12 tall Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State)
5039 The Akimeda Baltimore MD 21239 Home 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou To the Funer completely fi 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) BORNELL IME 261 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar BOSWELL, MD

31. Date filed (Month, Day, Year)

S. Greene St Baltimore MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 2012 Ам 1:00 ELLA В. CREASMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2008 E. MARLBORO AVENUE #204 HYATTSVILLE PRINCE GEORGE'S . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Min 239-64-7898 **Director** 1 🗆 M 2 🗓 K 72 APRIL 9, NORTH CAROLINA 1940 Usual Residence of Decedent show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 X Yes 2 □ No PRINCE GEORGE'S HYATTSVILLE MARYLAND 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2008 E. MARLBORO AVENUE #204 UNITED STATES 20785 death \ items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 🗶 No Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 X No Specify: "natural" Completed 3 X Widowed 4 Divorced BLACK Year or Dates the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) PRIVATE CHILD CARE PROVIDER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ADDIE COLSON **JAMES** HOUGH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 6711 COLUMBIA PARK ROAD, LANDOVER, MARYLAND 20785 BRIGITTE CONLEY / DAUGHTER item 2 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State ARLINGTON, VIRGINIA 5/14/2012 4 Donation 5 Other (Specify) ARLINGTON NATIONAL 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD, HYATTSVILLE, MARYLAND 20785 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Sause (Final Onset and Death Physician/ MALIGNANT NEOPLASM OF LIVER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Pregnant at time of death ed by the at detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autonsy performed? 2 No 1 Yes 2 **52** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 **X**No မှ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 XNatural 5 Pending iniury after death.

I Director: Af 2 No Accident Investigation М 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Funeral I Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Scertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one 29b. Signature at ACO00937 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MELONY REYNOLDS ANP 9200 BASIL COURT LARGO, MARYLAND 20774 31. Date filed (Month, Day, Year) State NAY 0 9 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

|         |                            |  |  | For  |                        | State  | of Marylar                                | •                             |                             |   |                   | and M           | 1ental Hy                     | gien             | 00   |                           | 1101   |    |  |  |  |
|---------|----------------------------|--|--|--|------------------------|--|---|-------------------------------|-----------------------------|---|-------------------|-----------------|-------------------------------|------------------|--|---------------------------|--|----|--|--|--|
|         |                            |  |  | State<br>Registrar   |                        |  |   | Cer                           | tificate                    | of D  | eath              |                 |                               | Reg. N           | . 21   | 112                       | 145  | t  |  |  |  |
|         |                            | Physicia<br>Medic  |  | Decedent's Name (  |                        | Last)<br>larie   | Rose                                      |                               | Corn                        | ely   |                   |                 | 2. Date of De<br>Month<br>May |                  | ay 20  | Year<br>012               | 3. Time of Death 10:20 F                           |    |  |  |  |
| (       | and a                      | Examin   |  | 4a. Facility Name (if no   |                        |  | ,   |                               | 4b. City,                   | Town, or  | Location o        | of Death        | •                             | 4c. County of De |  |                           |  |    |  |  |  |
| 1       | 7                          | / = T =  | М  | Stella Ma  |                        |  |   |                               |                             | imon  |                   |                 |                               |                  | Ba1  | imore                     |  |    |  |  |  |
|         |                            | Funeral<br>Director  |  | 5. Social Security Num<br>199–18–13  |                        | 5. Sex<br>1 □ M 2 💢 F  | 7. Age (In yrs. I.                        | ast birthday)<br>Yrs.         | If Under<br>Months          | 1 Year<br>Days  | If Under<br>Hours | 24 Hrs.<br>Min. | 8. Date of Bir<br>(Month, Da  | ay, Year)        | 0.5  | Counti                    | ,,   | gn |  |  |  |
|         |                            | d<br>fow   | _  | Usual Residence of I<br>10a. State 1   | Decedent<br>0b. County |  | 100 00                                    | Taum and an                   |                             |   |                   |                 | Feb. 7                        | ,19              | 25   |                           | sylvania   |    |  |  |  |
|         |                            | farylan<br>Ba-fsh<br>tified a  | <b>Funeral Director</b>  | MD   | ,                      | imore  | Tod. Cit                                  | y, Town or Loc                | cation                      | Ί   | imon              | ium             |                               |                  |  | 10                        | 0d. Inside City Limi<br>1  Yes 2                   |    |  |  |  |
|         |                            | the Na or 2  | ā  | 10e. Street and Numb   |                        |  |   |                               | 10f. Zip                    | Code  |                   |                 |                               | 10g. C           | itizen of V  | Vhat Count                | hat Country?                                       |    |  |  |  |
|         |                            | h with   | nera   | 2525 Pot   | Sprin                  | g Road   |   |                               |                             | 2   | 21093             |                 |                               | U                | nite   | i Stai                    | tes  |    |  |  |  |
|         | 936                        | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Š  | 11. Marital Status<br>1 ☐ Never Married<br>3 ፟፟፟ Widowed 4 [   |                        | 12. Was Dece<br>Armed Fo<br>d 1  Yes<br>If Yes, Giv<br>Year or D | edent Ever in U.S<br>prces?<br>2 No       |                               |                             | Decedent of Hispanic Origin? (Specify Yes or No-<br>, specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2 XNo Specify: |                   |                 |                               |                  | 14. Race - American Indian, Black, White, etc.  Specify: |                           |  |    |  |  |  |
| р.ш.    | 2-0                        | hours<br>natur<br>dical I  | lete   |  | 15. Decedent's         | s Education  | -   | 16a. Deced                    |                             |   |                   |                 |                               | 16b.             | Kind of Bu   | usiness/Ind               | White<br>ustrv                                     | _  |  |  |  |
|         | 121                        | thin 72<br>ene.<br>than "<br>he Mec  | Completed  | Elementary/Second  | dary (0-12)            | grade completed,<br>College (1                                   |   | life. DO                      | ind of worl<br>NOT use      | retired)  | uring most        | t of workii     | ng                            |                  |  |                           |  |    |  |  |  |
| 10:20   | d 2                        | led wi<br>Hygie<br>other<br>ent, t   | Be   | 12 Years 17. Father's Name (Fire   |                        | st)  |   | <u>Н</u>                      | <u>omema</u>                | <u>ker</u>  | 18. Mothe         | er's Name       | (First, Middle,               | Maider           |  | Home                      |  |    |  |  |  |
| 10      | ylan                       | ld be filed<br>Mental Hy<br>arked oth<br>atic event  | ပ  | Joseph   | E. McK                 | Cenna  |   |                               |                             |   |                   |                 | M. Roge                       |                  | ourname  | 7                         |  |    |  |  |  |
| 2012    | Maryland 21215-0036        | 2 should<br>lith and Me<br>27 is marl<br>r traumati  |  | 19a. Informant's Name Mr. Donal  |                        |  | Son<br>Jr.                                |                               |                             |   |                   |                 | Route Numbe                   |                  |  |                           | 17327  |    |  |  |  |
| 6, 2    | Baltimore,                 | Page 1 and πent of Hea ant: If item ury or other   |  | 20a. Method of Dispos  | sition<br>Cremation 3  | ☐ Removal from   | State 20b. F                              | lace of Disposemetery, crem   | sition (Nam<br>natory or ot | e of<br>her place   | )                 |                 | 7/2012                        | 20c. L           | ocation -  | City or Tov               | vn, State  |    |  |  |  |
| MAY (   | altin                      | permit. Pa<br>Departme<br>Important<br>any injury<br>once.   |  | 4 Donation 5   |                        |  | Mt.<br>el Leis                            | Pleas<br>er 22                |                             |   |                   |                 | Home o                        |                  |  | easant                    |  |    |  |  |  |
| Σ       | -                          | g or E to S  |  | Mai  | harf                   | FU   | lum                                       |                               | <u> 7922</u>                | Wis   | e Ave             | <u>∍. Dı</u>    | ındalk,                       | Maı              | ylar   | id 21                     | .222   |    |  |  |  |
|         | - F                        | Physician/   |  | 23a. Part 1, Enter the<br>shock, or heart for<br>Immediate Cause (Fin<br>disease or condition  | allure. List onl       | y one cause on ea  | caused the death<br>ich line.<br>GESTIVE  |                               |                             |   | , such as         | cardiac o       | respiratory ar                | rest,            |  |                           | Approximate<br>Interval Between<br>Onset and Death |    |  |  |  |
|         | 7                          | Medical<br>Examiner  |  | resulting in death)  | 1                      |  | or as a consequ                           |                               | FALL                        | JKE   |                   |                 |                               |                  |  |                           | <u>.</u>   |    |  |  |  |
|         |                            |  | iner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):   |                        |  |   |                               |                             |   |                   |                 |                               |                  | 50   |                           |  |    |  |  |  |
|         |                            | ate be executed<br>physician and<br>the burial-transit   | Exam   |  |                        |  |   |                               |                             |   |                   |                 |                               |                  |  |                           |  |    |  |  |  |
|         | 09                         | tte be e<br>hysiciar<br>the buri   | edical   |  |                        | d  |   |                               |                             |   |                   |                 |                               |                  |  |                           |  |    |  |  |  |
| ELY     |                            | aath certifica<br>attending p  | n/Me   | IF FEMALE:<br>23b. Was decedent pre  | egnant                 | 23c. If yes, out   | come of pregnar                           | ncy                           |                             |   |                   |                 |                               |                  | 23d Dat  | e of deliver              | N/   |    |  |  |  |
| CORNELY | O. Box 68                  | To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as             | Physician/M  | in the past 12 mo<br>1  Yes 2  N<br>9  Unknown   |                        | 1 🔲 Live<br>4 🔲 Preg<br>9 🗍 Unkr                                 | Birth 2 Feta<br>nant at time of d<br>nown | I death 3 L                   | Ectopic po<br>Other (spe    | regnancy<br>ec <i>ify)</i>  |                   |                 |                               |                  | Moi  |                           | y<br>Day Year                                      |    |  |  |  |
| MARIE   | s, P.(                     | is aw requires that the der<br>has been signed by the a<br>ge 2 should be detached   | þ  | Part II. Other significa   | nt conditions          | contributing to d  | eath but not resi                         | ulting in the ur              | nderlying ca                | ause give   | en in Part I      |                 | 23e. Did to                   |                  | -  |                           | cause of death?                                    |    |  |  |  |
| MA      | ord                        | requi<br>been<br>should  | lete   |  |                        |  |   |                               |                             |   |                   |                 | 24a. Was                      |                  | <u> </u>   |                           | sy findings available                              |    |  |  |  |
|         | Rec                        | sician: The law<br>certificate has<br>lirector, page 2   | Completed  |  |                        |  |   |                               |                             |   |                   |                 | autor<br>perfo                | SV               | D  | rior to com<br>eath?      | pletion of cause of                                |    |  |  |  |
|         | ta                         | ician:<br>sertific<br>ector,   | Be   | 25. Was case referred to examiner?   |                        | Hospital:  |   |                               |                             | _   | ce of Deat        | h (Check        |                               |                  |  |                           |  |    |  |  |  |
|         | ) t                        | ding Physician: h. After this certific, funeral director,  | 으  | 1 Li Yes 2 X N<br>27. Manner of Death  | 10                     | 1 28a. Date  | Inpatient 2  of injury                    | ER/Outpatient<br>28b. Time of |                             |   | 4 ∟ Nu            |                 |                               |                  |  |                           | HOSPICE  |    |  |  |  |
|         | ouo                        | ttending<br>death.<br>ctor: After<br>y the fune  | licate   | 1 X Natural 5  | Pending                | (Mont<br>ion   | th, Day, Year)                            | injury                        | M 28                        | c. Injury a<br>work?<br>1 \Bar Y  | es 2 🗆            |                 | 8d. Describe h                | iow injur        | y occurre  | d                         |  |    |  |  |  |
|         | Division of Vital Records, | To the Hospital or Attent<br>within 24 hours after death<br>To the Funeral Directors.<br>completely filled in by the   | 27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 4 Homicide 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 3 Pear 1 Pending 28b. Time of Injury 4 Pear 28b. T |  |                        |  |   |                               |                             |   |                   |                 |                               |                  | oute Number,   | ٦                         |  |    |  |  |  |
|         |                            | To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b  | Medical  | 29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  3 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                        |  |   |                               |                             |   |                   |                 |                               |                  |  | l.<br>e(s) and manner sta | ted.   |    |  |  |  |
|         | ;<br>-                     | vithir<br>Comp   |  | 29b. Signature and title   | of certifier           |  | - 1                                       | ,                             |                             | License r   |                   | o arrai proto   |                               |                  |  | (Month, Da                |  |    |  |  |  |
|         |                            | (000   |  |  | 110                    | en   | _DN                                       | PINF                          |                             | RI  | 30                | 2               | 12                            |                  | 51   | 7/1                       | 2  |    |  |  |  |
|         | -                          | Om   |  | 30. Name and address  TRACIE L.  |                        |  |   |                               |                             | EV n  | י מי              | TT1401          | NIUM. M                       | m •              | 1000   | •                         |  |    |  |  |  |
|         |                            | State  | -  | 31. Date filed (Month, E   | Day, Year)             | <b>3</b> 32. Re  | egistrar's Signat                         | ure                           | VALL                        | EI K  | <b>.</b>          | TIMU            | ALUM, M                       | ш /              | 1093   |                           |  |    |  |  |  |
|         |                            | Registra   |  | MAINS  | ZUIZ                   | 1 Haller 1   | 14. 140                                   | -                             |                             |   |                   |                 |                               |                  |  |                           |  |    |  |  |  |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 CLARK DORIS  $\mathbf{OI}^{\mathsf{Day}}$ 2012 10:37p <sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 1505 North Rolling Road Apt 214 Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 82 217-26-2385 Director 15 29 MD **b**8 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Randallstown MD Baltimore 1 Yes 2 No ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 21228 214 1505 North Rolling Road Apt items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ō 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Hochschild Kohns <u>Sales Representative</u> 8th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown ည Jessie Hogan Page 1 and 2 should I nent of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. Doris Jackson-Daughter 20a. Method of Disposition Baltimore, Md 21216 2422 West Lanvale Street, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State King Memorial Park 5/9/2012 Woodlawn, Md Ponation 5 Cther (Specify) ure of Funeral Service Licensee 22. Name and Address of Eacility
March F/H West 21. Sign 4300 Wabash Ave, Baltimore, Md 23a. Partif. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final International Cause (Final Internation Interval Retween Onset and Death Physician/ M. W. 25 disease or condition MYOCARDA INFARCTION Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the burial-transit executed Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the s 9 Unknown P.O. be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, or Attending Physician: The law requires DIABETES MERCITUS 1 Yes 2 No 3 Probably 4 Unknown Completed should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed certificate 1 Yes 2 🗌 No Yes Division of Vital filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No 1 Tes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes s after death. 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital within 24 hours of to the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 L 3 L only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAY 04, 2012 000258 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIS 418 COMMERTORD 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:13PM ARIAN 2012 Medical not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AUTIMOR 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 1 M 2 X MD03-26-28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director notified MD1 X Yes 2 No ALTIMORE 10e. Street and Number 10g. Citizen of What Country? must be r 23a IMMS 21206 WENUE 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ō by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐No Specify: "natural", Completed 3 Widowed 4 Divorced BLACK Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Sto City Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) SCHOOLS NUTRIONIST D Be aryland 18 Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) ٥ BLAGMOND 1)16-65 and l Informant's Name/Relationship (Type, Print) DAUGHTER or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of Important: If it any injury or o ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, BALTIMORE, MD 112 4 Donation 5 Other (Specify) EDEEMER GREENE FUNERAL SU 21. Signature of Funeral Service License VAUGHN 22. Name and Address of Facility MD. 21212 23a. Part 1. Enter the dise shock, or heart failure death. Do not enter the mode of dying, ons that caused the such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Pregnant at time of death 5 Other (specify) Day Month Year 1 ☐ Yes ∠ ₩ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 246. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy performed Yes 2 N 1 Yes 25. Was case referred to me Be 26. Place of Death (Check only one) examiner? ျ 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Certificate: eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 03 31. Date filed (*Month, Day, Year*) **MAY 0 9 2012** 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ <sup>Day</sup> 2012 Harry Lee Collier, Sr. May 12:55 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mandrin Inpatient Care Center Harwood Anne Arundel 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. **Funeral** Min. **Director** 296-16-5809 1 52 M 2 🗆 F 88 September 4, 1923 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director notified 28a-f 1 🗌 Yes 2 🙀 No Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be Funeral 1277 Ritchie Highway 21012 United States items 12. Was Decedent Ever in U.S Armed Forces? 104 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 X Yes 2 No 1943— If Yes, Give Year or Dates. 1945 Black, White, etc. þ ō 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2x No Specify White "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) er than the Me Elementary/Secondary (0-12) College (1-4 or 5+) Welder Boilermaker Be 17. Father's Name (First, Middle, Last) t of Health and Mental H If item 27 is marked oth or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) မ Martin P. Collier Marilla Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma E. Collier/Wife 1277 Ritchie Highway, Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State ō May Department of Important: If any injury or 2012 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Maryland 21. Signature of Fun Service Licenses 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 ARIEL M01386 23a. Part 1. Enter the disease, or complesshock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. set and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequency of **Examiner** Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Due to lor as a consequence of Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death signed by the at the detached for 2 No 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 10 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy death? this certificate 1 Yes filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 Other: 1 🗌 Yes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Director: After 1 - atural 5 Pending injury work? Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2756 2010

State Registrar

DHMH 17 Rev 06-2011

Marian

31. Date filed (Month, Day,

Wetense

30. Name and address of person who completed cause of death (Item 23a) (Type, Prin

445

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5:22 Mau 201 LORENE O. CEPHAS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death BaltimDr N/A Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) vrs. last birthday **Funeral** 218-28-8060 80 Director 1 🗆 M 2 🗓 F 11-23-1931 MARYLAND Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No N/A MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3534 LYNCHESTER RD. 21215 USA an "natural", or items Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify BLACK Specify 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the -12--8-ATTORNEY SOCIAL SECURITY marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ath and Mental h ပ CHARLES W. CEPHAS SARAH HENSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i BARA R. CEPHAS (DAUGHTER) 3534 LYNCHESTER RD. BALTIMORE, MARYLAND 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 2 Crer 1 X Burial WOODLAWN CEMETERY 5-14-2012 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, PA. Tineral Service 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Drune 10 Dreumenia Medical Examiner nnunosu Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury and that initiated events resulting in death) Last physician a the burial-Physician/Medical as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months? Month Year Day ed by the a 9 Unknown P.O. signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ e and chronic Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Diabetes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 performed' 2 No Yes 2 No Yes Vital 25. Was case referred to medical or Attending Physician: Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes မှ 🖊 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 \( \subseteq \) Nursing Home 5 \( \subseteq \) Residence 6 \( \subseteq \) Other (Specify) Division of 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending work? 2 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Reed

DHMH 17 Rev 06-2011

State Registrar

EPHAI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc g927 5-9-12 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY 2012 ANITA COHEN 12:05P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TOWSON BALTIMORE GILCHRIST HOSPICE CARE 5. Social Security Number If Unde 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 215-40-2181 Director 1 □ M 2 💢 F 70 03/10/1942 MD Usual Residence of Decedent 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE BALTIMORE 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Medical Examiner must be Funeral items 23a 9205 HOWARD SQUARE DRIVE USA 21208 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 X Married 1 Yes 2 X No If Yes, Give Year or Dates. "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. WHITE Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Anitacohen CUSTOMER SERVICE REP. **AUTO SALES** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. **EDWARD EPSTEIN** DOROTHY **BOGRAD** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9205 HOWARD SQUARE DRIVE, BALTIMORE, MD 21208 GERALD COHEN/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05/06/2012 | BALTIMORE, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused shock, or hear failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ Head injury disease or condition Medical resulting in death) Due to (or as a construence of) Examiner turus Sequentially list conditions, Examine Due to (or as a consequence of); if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events J physician and as the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ō in the past 12 months? Day Year signed by the a 1 ☐ Yes ≥ L 9 ☐ Unknown Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 mona Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed?

1 Yes 2 No death? this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home edence 6 😾 Other (Specify) hospice funeral 28a. Date of injury (Month, Day, Year) (35/62/2012 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After t completely filled in by the funeral 28d. Describe how injury occurred 1 Natural
2 Accident
3 Solicia 5 Pending injury unknow\" Investigation 6 Could not be 28f. Location (Street and Number of Bural Route Number, City or Town, State) 7205 40000 505 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated State Registrar

75

J

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|   |  |              | For Amend Item 2   | ate of Maryla<br><b>3a per dr</b>  | and Departure 1997,0     | stment of l<br>5/29/201<br>tificate of L               | lealth and M<br><b>2dhb</b><br>Death                                     | 1ental Hy                       | giene<br>Reg. No. 20  | 12 14622   |
|---|--|--------------|--|--|--------------------------|--|--|---------------------------------|-----------------------|--|
|   | Physicia<br>Medi   |              | 1. Decedent's Name (First, Middle, Last)  Rebecca  | Ch   | ARKA                     | 172  |  | 2. Date of Dea                  | 3 2 0 1               | ear 3. Time of Death   |
| 0   | Exami  |              | 4a. Facility Name (if not institution, give street SEASONS HOSPICE @ NO  | and number)  |                          | 4b. City, Town, or                                     | r Location of Death  |                                 | 4c. County of         | Death TIMORE   |
|   | Funeral<br>Director  |              | 5. Social Security Number   6. Sex   212–18–7976   1 \(  \te | 7. Age (In yr  | s. last birthday)        | If Under 1 Year Months Days                            | If Under 24 Hrs. Hours Min.  | 8. Date of Birt<br>(Month, Day  | h g<br>y, Year)       | ). Birthplace (State or Foreign<br>Country)                                |
|   |  |              | Usual Residence of Decedent  10a. State 10b. County  | 9  | 3 Yrs. City, Town or Loc | ation  |  | 02/24/                          | 1919                  | NY 10d. Inside City Limits   |
|   | e Maryk<br>r 28a-f s<br>notified   | Director     | MD BALTIMORE   |  | BALTIMOI                 |  |  |                                 |                       | 1 Tyes 2x No   |
|   | s 23a o<br>ust be  | Funeral      | 9 OLD PLANTATION W   | 'AY  |                          | 10f. Zip Code 212                                      | 208  |                                 | 10g. Citizen of Wha   | at Country?  |
| 036                                       | s after death<br>ral", or item<br>Examiner m   | <u>\$</u>    | 1 Never Married 2 Married 1  | as Decedent Ever in<br>med Forces?<br>□ Yes 2 ☒ No<br>Yes, Give<br>aar or Dates. |                          | /as Decedent of H<br>Yes, specify Cuba<br>☐ Yes 2 X No | ispanic Origin? (Spe<br>In, Mexican, Puerto I<br>Specify:                | cify Yes or No-<br>Rican, etc.) |                       | American Indian, White, etc. WHITE   |
| Baltimore, Maryland 21215-0036            | I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at  | Completed    | 15. Decedent's Educatio (Specify only highest grade cor Elementary/Secondary (0-12)  |  | (Give k                  | NOT use retired)                                       | ation<br>during most of worki  | ng                              | 16b. Kind of Busin    |  |
| pur                                       | e filed w<br>ntal Hygi<br>ed othe<br>event,  | To Be        | 17. Father's Name (First, Middle, Last)  |  |                          | LIC  | 18. Mother's Name  | (First, Middle, i               |                       |  |
| aryla                                     | nould be<br>ind Mer<br>s marke<br>umatic   |              | MORRIS  19a. Informant's Name/Relationship (Type, Pri  |  | HWARTZ<br>19b. Mailin    | a Address (Street                                      | CELIA and Number or Rura   | l Route Number                  | : City or Town. State | PERL   |
| Ğ,  | and 2 stand 2 stand 2 stand 2 stand 27 is sm 27 is ther tra  |              | ANN DAVIS/DAUGHTER   | Law  | 9 01                     | D PLANTA   | TION WAY,  | BALTIN                          | ORE, MD               | 21208  |
| e ii                                      | Page<br>nent c<br>ant: If<br>ary or  |              | 1 X Burial 2 ☐ Cremation 3 ☐ Remo<br>4 ☐ Dopation 5 ☐ Other (Specify)  | val from State   | -                        | atory or other plac                                    | ERY 05/06  | 5/2012                          | 20c. Location - Cit   | ty or Town, State  |
| Balt                                      | permit. Page<br>Department<br>Important: I<br>any injury o   |              | 21. Signatura of Furreral Service License  | 19ec   |                          | Name and Addres  | ss of Facility SC  |                                 | ISON & BR             | OS., INC.  |
| P   | hysicism/  |              | 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus Immediate Cause (Final disease or condition  | ng inat caused the de<br>don each line. At                                       | eath. Do not ente        | the mode of dying                                      |  | r respiratory arre              | est,                  | Approximate Interval Between Onset and Death                               |
|   | Medical<br>Examiner  |              | resulting in death)  | ue to (or as a conse   | equence of):             |  |  |                                 |                       |  |
| 70  | d<br>ansit   | Examiner     | cause (Disease or injury that initiated events   | Due to (or as a conse  | equence of):             |  |  |                                 |                       |  |
| 90  | te be executed<br>nysician and<br>he burial-transit  | dical        | resulting in death) Last   | Due to (or as a conse  | equence of):             |  |  |                                 |                       |  |
| 9289                                      | ding ph  | /Mec         | IF FEMALE: 23c. If:  | ves, outcome of preg   | nancy                    |  |  |                                 |                       |  |
| ). Box                                    | on the attentiached for u  | Physician/Me | in the past 12 months?   | Live Birth 2 For Figure 2 Pregnant at time correct Unknown                       |                          | Ectopic pregnanc<br>Other (specify)                    | у  |                                 | 23d. Date o<br>Month  |  |
| Division of Vital Records, P.O. Box 68760 | requires that the beath certifications signed by the attending phishould be detached for use as the  | by           | Part II. Other significant conditions contribut  | ing to death but not r   | esulting in the ur       | derlying cause giv                                     | en in Part I.  |                                 | es 2□No 3[            | te to the cause of death?  |
| I Reco                                    | sicial. The law is certificate has b lirector, page 2 s.   | Completed    | 25. Was case referred to medical   |  |                          | 00 Pi  | 10. 11.6%  | 24a. Was a autopoperfor         | med? prio             | e autopsy findings available r to completion of cause of th? Yes 2 \sum No |
| Vita                                      | his cert   | To B         | examiner? 1  Yes 2 No Hospita  | 1 Inpatient 2  |                          | Otho   | ace of Death <i>(Check</i><br>er: 4 \(\text{\text{\text{Prising Hor}}}\) |                                 | ence 6 Aother (S      | DOS PICE   |
| ion of                                    | uriting 24 hours after death.  To the Funeral Director After this certific completely filled in by the funeral director.   | ertificate:  | 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be  | a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury      |  |  | 8d. Describe ho                 | ow injury occurred    |  |
| Divis                                     | urs after of ral Direct of ral | ပ            | 4 ☐ Homicide determined 286  | e. Place of Injury - At<br>building, etc. (Spec                                  | ify)                     |  |  | City or Town                    | n, State)             | r Rural Route Number,  |
| the Hoer                                  | within 24 ho To the Fune completely f  | Medical      | only one) 3 LJ Certifying Nurse Prac   | the basis of examinat  | ion and/or investi       | gation, in my opinio<br>death occurred at the          | n, death occurred at<br>ne time, date and place                          | the time, date an               | d place, and due to   | the cause(s) and manner stated.  |
|   | P P P P P P P P P P P P P P P P P P P  |              | 29b. Signature and title of certifier  | The  | M                        | 29c. License   | number 72  |                                 | Pd. Date signed (M    | - in   |
| 0   |  |              | 30. Name and address of person who complet   | 693  | 4 1                      | DVIA   | hin bi   | Ivd .                           | Alen B                | 2012<br>4011,21061   |
|   | Sta<br>Registra  | .6           | NAY 0 9 2012   | 32. Registrarle Sign   | factore factor           |  |  |                                 |                       |  |
| Je DHMI                                   | H 17 Rev 06-2  | 2011         |  |  |                          |  |  |                                 |                       |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 24 Month Iris M. Coward 2012 19:19 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltmore N/A If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 3 7 – 3 6 – 3 6 7 3 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 1 🗆 M 2 🗶 F 83 12/28/1928 Ν. Carolina ral", or items 23a or 28a-f show Examiner must be notified at within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A 1 XYes 2 No Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 3805 Howard Park Ave. 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or 9 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than ntary/Secondary (0-12) College (1-4 or 5+) 12th Grade Social Worker City of New York permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nathaniel Coward Bertha Kornegay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Essie Audain(sister) 3805 Howard Park Ave., Baltimore, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State on-site Creamtory () 4 Donation 5 Other (Specify) Baltimore, MD Signature of Funeral Service License Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Sepsis disease or condition days Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months? Year signed by the at d be detached fo Yes 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CVA WITH Vascular dementia, Atrial Fibrillation, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Severe pulmonary HTN (hypertension) 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 1 Natural 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending iniurv Accident 1 Tes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie April 24, 2012 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aileen. Parl, M.D., Sinai Hospital of Baltimore State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May Physician/ 2012 6:15 P Patricia Martha David Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. Stella Maris Hospice Center Timonium Social Security Number Year If Under 24 Hrs Date of Birth (Month, Day, Year) . Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours Director 214-18-7385 1 🗆 M 2 🗶 F 91 Yrs March 17,1921 Maryland Usual Residence of Decedent or 28a-f show 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits be notified at Director Yes 2 No N/A MD Baltimore City 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral must I 2830 Dillon Street 21224 United States "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status Was Decedent Ever in U.S. 14 Race - American Indian. Armed Force 1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 X Widowed 4 ☐ Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Menones Elementary/Secondary (0-12) College (1-4 or 5+) 8 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Peter Czerkowski Martha Kowalski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Riley (Daughter) 18925 Brick Store Road Hampstead, Maryland 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Removal from State 5/8/2012 St. Stanislaus Cem. Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Scott P. Gardner Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk. Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Phylician disease or condition resulting in death) GASTROINTESTINAL BLEED Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No detached for Day Year Pregnant at time of death 9 Unknown g Unknown signed by t d be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed?

Yes 2X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No Other: မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 T Other (Specify) HOSPICE After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural iniury 5 Pendina eral Director: A Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

Registrar DHMH 17 Rev 06-2011

State

Medical

29a. Certifier

(Check

29b. Signature and

JACKIE JONES, CRNP

2300 DULANEY VALLEY RD.

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 🕱 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                     |   |                  | For State of Maryland  | / Department of                                       | of Health and I   | Mental Hy                        | giene 20                          | 12 1462  |  |  |
|---------------------|---|------------------|--|---|---|----------------------------------|-----------------------------------|--|--|--|
|                     |   |                  | State Registrar  | Certificate of  | of Death  |                                  | Reg. No.                          | 12 1402.   |  |  |
|                     | Physicia<br>Medic   |                  |  | nklin Daiger  |   | 2. Date of De<br>Month<br>May    | Day Year                          |  |  |  |
|                     | Examin  | ner              | 4a. Facility Name (if not institution, give street and number)  Blue Point Nursing & Rehab Ctr.  | • Bal   | n, or Location of Death<br>timore Cit                             |                                  | 4c. County of Dea                 | N/A  |  |  |
| K                   | Funeral<br>Director   |                  | 5. Social Security Number 6. Sex 7. Age (In yrs. last in Liquel Residence of Decedent 83   |   | ear If Under 24 Hrs.<br>ays Hours Min.                            | 8. Date of Bir<br>(Month, Da     | y, Year) C                        | irthplace (State or Foreign<br>country)          |  |  |
|                     | yland<br>f show<br>ed at  | iğ               | Osual residence of Decedent  | Town or Location                                      |   | Jan.                             | 16,1929   V                       | 10d. Inside City Limits                          |  |  |
|                     | the Mar<br>or 28a-<br>e notifie   | Funeral Director | MD Baltimore  10e. Street and Number   | 10f. Zip Co   | Notting   | gham                             | 10g. Citizen of What C            | 1 ☐ Yes 2XX No<br>t Country?                     |  |  |
|                     | n with  | Dera             | 9513 Holiday Manor Road  | 21  | 236   |                                  | United St                         | ates   |  |  |
| 36                  | should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 25a or 28a-f show are armined to be notified at armine must be notified at  |                  | 11. Marital Status  1 □ Never Married 2 X Married  3 □ Widowed 4 □ Divorced  3 □ Widowed 4 □ Divorced  | If Yes specify (                                      | of Hispanic Origin? (Sp<br>Cuban, Mexican, Puerto<br>Who Specify: | ecify Yes or No-<br>Rican, etc.) | Black, Wh                         | ite, etc.  |  |  |
| 2-00                | 2 hours a<br>"natural<br>edical Ex  | Completed by     | Year or Dates.   | 16a. Decedent's Usual Oc                              |   | kina                             | 16b. Kind of Busines              | White<br>s/Industry                              |  |  |
| Maryland 21215-0036 | within 7.<br>giene.<br>her than<br>t, the Me  |                  | Elementary/Secondary (0-12) College (1-4 or 5+)  8 Years   | life. DO NOT use reti<br>Maintenance                  | red)  |                                  | Baltimor                          | e City   |  |  |
| land                | ould be filed wit<br>nd Mental Hygie<br>marked other<br>matic event, th   | To Be            | 17. Father's Name (First, Middle, Last)  Arthur B. Daiger  |   |   |                                  | Maiden Surname) Kilman            |  |  |  |
| Mary                | permit. Page 1 and 2 should be fi<br>Department of Health and Mental<br>Important: If item 27 is marked<br>any injury or other traumatic ev   |                  | 19a. Informant's Name/Relationship (Type, Print)  Mrs. Dorothy S. Daiger (Wife)  | 19b. Mailing Address (Str<br>9513 Holid               |   |                                  |                                   | Zip Code)<br>Maryland 21236                      |  |  |
| Baltimore,          | ge 1 and<br>nt of Hea<br>nt if item<br>or othe  |                  | 20a. Method of Disposition  1 ABurial 2 Cremation 3 Removal from State   | ce of Disposition (Name of netery, crematory or other | place)  | Date                             | 20c. Location - City of           | ·  |  |  |
| Saltin              | ermit. Pa<br>epartmer<br>nportant<br>ny injury<br>nce.  |                  | 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens (Tegory)  Ree  | Lawn Cemet  |   | /2012<br>Home of                 | Baltimor<br>Dundalk, I            | e, Maryland                                      |  |  |
| _                   | <u> </u>  |                  | 23a. Part 1. Enter the disease, or complications that caused the death. D  | 7922 Wis  | se Ave. D   | undalk.                          | Maryland                          | 21222  |  |  |
|                     | h, sician/  |                  | shock, or head failure List only one cause on each line. Immediate Cause (Final disease or condition C A R D I A C   | c arythei   | ,   | or respiratory ar                | rest,                             | Approximate Interval Between Onset and Death HIR |  |  |
|                     | Medical<br>Examiner   |                  | resulting in death)  Due to (or as a consequence of the rose of th | ice of):<br>Herotic he                                | out dise  | cusic                            |                                   | 5 423  |  |  |
|                     | uted<br>d<br>ansit  | Examiner         | if any leading to immediate Due to (or as a consequent cause. Enter Underlying   | to ch   |   |                                  |                                   | 154125   |  |  |
| 0                   | ate be executed<br>physician and<br>the burial-transit  | dical Ex         | resulting in death) Last Due to (or as a consequence   | ice of):  | feii lure   |                                  |                                   | lyr  |  |  |
| 3760                | ificate I<br>ig phys<br>as the  | Medi             | - u  |   |   |                                  |                                   |  |  |  |
| Box 68              | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Me     | IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1 ☐ Yes 2 ☐ No g ☐ Unknown   1 ☐ Unknown   23c. If yes, outcome of pregnancy   1 ☐ Live Birth 2 ☐ Fetal de   1 ☐ Pregnant at time of deat   1 ☐ Pregn    | leath 3 Ectopic preg                                  |   |                                  | 23d. Date of d<br>Month           | elivery<br>Day Year                              |  |  |
| P.O.                | s that the<br>gned by oe detacl   | by Ph            | Part II. Other significant conditions contributing to death but not resulting  | , ,   | 0   | 23e. Did to                      | obacco use contribute t           | to the cause of death?                           |  |  |
| Records,            | requires<br>been siç<br>should t  | Completed        | popkinson's disease seizi  | ures dison  | lev   | 1 🗆<br>24a. Was                  |                                   | Probably 4 Unknown utopsy findings available     |  |  |
| Rec                 | : The law<br>cate has<br>r, page 2  |                  |  |   |   |                                  | psy prior to<br>prmed? death?     | completion of cause of                           |  |  |
| ıta                 | sician: The<br>certificate<br>lirector, pag   | o Be             | 25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 I postiont 2 FB.   |   | 6. Place of Death (Checo  |                                  |                                   |  |  |  |
| n of                | iding Physician: th. After this certific: funeral director,   | cate: To         | 1 inpation 2 in the  | Bb. Time of 28c. I                                    | 4 L Nursing H<br>njury at<br>work?<br>1 □ Yes 2 □ No              |                                  | dence 6 Other (Spe                | ecify)   |  |  |
| Division of Vital   | il or Atter<br>after dea<br>Director<br>d in by the   | Certificate:     | 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home building, etc. (Specify)   |   |   | 28f. Location (\$<br>City or Tox | Street and Number or Rivn, State) | ural Route Number,                               |  |  |
| _                   | To the Hospital or Attend<br>within 24 hours after death<br>To the Funeral Director<br>completely filled in by the  | Medical          | 29a. Certifier (Check 2 Medical Examiner: On the basis of examination an only one) 3 Certifying Nurse Practitioner: To the best of my knowledge  | nd/or investigation, in my o                          | pinion, death occurred a  | it the time, date a              | and place, and due to the         | cause(s) and manner stated.                      |  |  |
|                     | vithir<br>To th<br>comp   | Σ                | 29b. Signature and title of certifier  |   | ense number   |                                  | 29d. Date signed (Mon             |  |  |  |
|                     | ml.   |                  | Mesa * DESA  | ,   | 30494   |                                  | 5-7-80                            | 12   |  |  |
|                     | 31.8.   |                  | 30. Name and address of person who completed cause of death (Item 23)  | Ice lane Ba   | Immore m  | ישוצי מי                         | ર ટ                               |  |  |  |
|                     | Stat<br>Registra  |                  | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |   |   |                                  |                                   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decede s Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Na Sity, Town, or Location of Death County of Death **Examiner** ge (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State of Foreign PA 8. Date of Birth **Funeral** 1 🗆 M 2 😾 F Allenth, Days Year) 1918 Months Hours Min. Director 199-01-8378 93 Usual Residence of Decedent 10a. State 10c. City, Town or Location the Maryland 10d. Inside City Limits Director or 28a-f st notified a 1 Yes 2 X No MD Prince George's Beltsville 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be by Funeral permit. Page 1 and 2 should be filed within 72 hours after death with USA 13003 Key Street 20705 items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 Exar If Yes Give 1 Yes 2XXNo Specify: "natural", Specify: White Completed 3 X Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Mental Hygiene. Teacher Education Be 17. Father's Name (First, Middle, Last) of Health and Mercal frem 27 is marked of a ther traumatic eve 18. Mother's Name (First, Middle, Maiden Surname) မ Anne Wargo John Lazas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20705 daughtet 13003 Key Street Beltsville, Maryland Mary Elizabeth BOrges 20a. Method of Disposition
1 ☐ Burial 2 XX cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ō Important: If it any injury or o W. Arundel Crematory 5/8/2012 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 ee, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1, Enter the dise Approximate Interval Between shock, or heart failure ist only one cause on such line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnan 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months 5 Other (specify) Month Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2. No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 No Yes 24 1 Yes Be 25. Was case referred to all all examiner? 26. Place of Death (Check only one) Hospital: Other: MNO ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of pe

31. Date filed (Month, Day, Year)

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

|  |   |                  | For  | State                                     | e of Maryla   |                        | artment of H                                 |                              | Mental Hy                       | giene ,                             | 0010                      |              | 1 60                    |
|--|---|------------------|--|---|---|------------------------|--|------------------------------|---------------------------------|-------------------------------------|---------------------------|--------------|-------------------------|
|  |   |                  | State<br>Registrar   |   |   | Cer                    | tificate of D                                | Death                        |                                 | Reg. No.                            | 2012                      | 1            | 462                     |
| П  | Physicia  | in/              | 1. Decedent's Name (First, Mic   |   | hini Iv   |                        |  |                              | 2. Date of De                   | eath Day                            | 75 Year                   |              | of Death                |
|  | Medic   | al               | Joseph   |   | ıbiel, Jr   | •                      |  |                              | 1//0/01                         | +)                                  |                           | 2-1          | 7P M                    |
|  | Examin  | er               | 4a. Facility Name (if not instituted Baltimore W   |   |   | Contor                 |  | Location of Death            |                                 | 4c. Co                              | unty of Death Anne        | A rund       | o 1                     |
|  | Funeral   |                  | 5. Social Security Number  | 6. Sex                                    |   | last birthday)         | If Under 1 Year                              | If Under 24 Hrs.             | 8. Date of Bir                  | th                                  |                           |              | e or Foreign            |
|  | Director  |                  | 218-42-5984  | 1 🔀 M 2 🗆                                 | F   | Yrs.                   | Months Days                                  | Hours Min.                   | (Month, Da                      |                                     | Cour                      | try)         |                         |
|  | d<br>ow<br>t  |                  | Usual Residence of Deceder<br>10a. State 10b. Cou  |   | 68  |                        |  |                              | 09/23                           | 3/1943                              |                           | MD           |                         |
|  | rylan<br>I-f sh<br>ied a  | cto              |  |   |   | City, Town or Lo       |  | 11 70                        |                                 |                                     |                           |              | City Limits             |
|  | r 28a<br>notif  | Dir.             | MD An  | ne Arunde                                 | ;T  |                        | 10f. Zip Code                                | len Burn                     | ile                             |                                     | 4116                      |              | ′es 2 🏻 No              |
|  | vith th   | al               |  | and Count                                 |   |                        | Toi. Zip Code                                | 21061                        |                                 | 10g. Citizen                        | of What Coul              | S.A.         |                         |
|  | within 72 hours after death with the Maryland<br>giene.<br>er than "natural", or items 23a or 28a-f show<br>the Medical Examiner must be notified at  | Funeral Director | 11. Marital Status   |   | Decedent Ever in L  |                        | Vas Decedent of His                          | spanic Origin? (Sp           | ecify Yes or No-                | 14.                                 | Race - Americ             |              |                         |
| 9  | ter de<br>, or it   | by               | 1 Never Married 2 🛛  | farried 1 🔼                               | d Forces?<br>Yes 2 \( \subseteq \text{No} \)                | l'                     | Yes, specify Cubar                           | n, Mexican, Puerto           | Rican, etc.)                    |                                     | Black, White,             |              |                         |
| 93   | urs af<br>ural"<br>al Exa   |                  | 3 Widowed 4 Divor  | ed If Yes,<br>Year o                      | , Give<br>or Dates.   | 1                      | Yes 2 No                                     | Specify:                     |                                 | Spe                                 | ecify: Wh                 | ite          |                         |
| 21215-0036   | 72 ho   | Completed        | 15. Dece<br>(Specify only hi   | dent's Education<br>ghest grade comple    | ted)  | (Give I                | ent's Usual Occupa<br>aind of work done d    | ation<br>Juring most of work | king                            | 16b. Kind                           | of Business/In            | dustry       |                         |
| 12   | J within 72<br>ygiene.<br>her than '  | 9                | Elementary/Secondary (0-1  | 2) Colleg                                 | je (1-4 or 5+)  | life. Do               | One described)                               | ~ C11-                       |                                 |                                     | TAT (                     | S.A.         |                         |
| d 2  | filed wit<br>al Hygie<br>d other<br>event, th   | امها             | 17. Father's Name (First, Middl  | e, Last)                                  |   |                        | Ordering                                     | 18. Mother's Nan             | ne (First Middle                | Maiden Surr                         |                           | ) . A .      |                         |
| an   | be fi<br>lental<br>rked<br>ic ev  | 은                | Joseph J.  | Dubiel                                    |   |                        |  | Claire                       | Elaine                          |                                     | ,                         |              |                         |
| Maryland   | should be file<br>n and Mental h<br>7 is marked o<br>raumatic eve   |                  | 19a. Informant's Name/Relation   |   |   | 19b. Mailin            | g Address (Street a                          |                              |                                 |                                     |                           | Code)        | 21061                   |
|  | 1 and 2 should be filed within 72 hour if Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical   |                  | Mrs. Virginia  | M. Dubie                                  | 1 / wife  | 1                      |  | od Court                     |                                 |                                     | rnie, N                   |              | and                     |
| ore  | e 1 ar<br>of He<br>If iter<br>ir oth  |                  | 20a. Method of Disposition  1 🛣 Burial 2 🗀 Cremati   | an 3 🗆 Romoval f                          |   | Place of Dispo         | sition (Name of<br>natory or other place     | e)                           | Date                            | 20c. Locati                         | ion - City or To          | wn, State    |                         |
| ij   | Page 1<br>ment of<br>tant: If it<br>lury or o   |                  | 4 Donation 5 Othe  |   | G1  |                        | n Mem. Pa                                    |                              | 1/2012                          | Glen                                | Burnie                    | , Mai        | ry1and                  |
| Baltimore,   | permit. Page 1<br>Department of<br>Important: If i<br>any injury or c   |                  | 21. Signature of Funeral Service   | e Licensee                                |   |                        | Name and Addres                              | s of Facility 1              | 2nd Ave                         | e, SW                               | Glen                      | Burn:        | ie, MD                  |
|  | 70 = 60   |                  | Jan 11   | Van                                       |   |                        | ngleton 1                                    |                              |                                 |                                     | ervices                   | , P.A        | A.                      |
| 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as car liac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  A Disease a recognization of the cause of the ca |   |                  |  |   |   |                        |  |                              |                                 | Approxim<br>Interval B<br>Onset and | etween                    |              |                         |
|  |   |                  |  |   |   |                        |  |                              |                                 |                                     | Onset and                 | d Death      |                         |
| 1  | Examiner  |                  | ,  | Due                                       | to (or as a consec  | quence of):            |  |                              |                                 |                                     |                           |              |                         |
|  |   | Je.              | Sequentially list conditions, if any, leading to immediate   | Due                                       | to (or as a consec  | quence of):            |  |                              |                                 |                                     |                           |              |                         |
| p  | uted<br>d<br>ansit  | ami              | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events   | 5   |   |                        |  |                              |                                 |                                     |                           |              |                         |
| 3  | exec  | <u>~</u>         | resulting in death) Last   | Due                                       | to (or as a conse   | quence of):            |  |                              |                                 |                                     |                           |              |                         |
| Box 68760  | ate be executed<br>physician and<br>the burial-transit  | edical Examiner  |  | d   |   |                        | -  |                              |                                 |                                     |                           |              |                         |
| 387  | artifica<br>ding p  |                  | IF FEMALE:   | Ogo Huno                                  | autoama of mean   |                        |  |                              |                                 |                                     |                           |              |                         |
| ) XO   | ath ce<br>attenc<br>for us  | cian             | 23b. Was decedent pregnant in the past 12 months?  | 1 🗆 L                                     | outcome of pregr<br>live Birth 2  Fe<br>Pregnant at time of | tal death 3            | Ectopic pregnancy<br>Other (specify)         | y                            |                                 | 23d.                                | . Date of delive<br>Month | ery<br>Day   | Year                    |
| Ď.   | the described   | ysi              | 1 Yes 2 No<br>9 Unknown  |   | Jnknown   | dealii 3 L             | Other (specify)                              |                              |                                 |                                     |                           | Day          | 1001                    |
| Division of Vital Records, P.Ó   | requires that the death certific<br>been signed by the attending I<br>should be detached for use as   | by Physician/M   | Part II. Other significant conc  | itions contributing                       | to death but not re   | sulting in the u       | nderlying cause give                         | en in Part I.                | 23e. Did t                      | obacco use c                        | contribute to th          | e cause of   | death?                  |
| JS,  | uires<br>in sign<br>uld be  |                  |  |   |   |                        |  |                              | 1 🗆                             | Yes 2 🗆 N                           | lo 3 🗆 Prot               | ably 4       | Unknown                 |
| Ö  | w req   | plet             |  |   |   |                        |  |                              | 24a. Was                        |                                     | 4b. Were autor            |              |                         |
| Rec  | sician: The law is certificate has the director, page 2 s   | Completed        |  |   |   |                        |  |                              | autor<br>perfo                  | ormed?<br>2 No                      | prior to coldeath?  1 Yes |              | cause or                |
| ā  | ysician:<br>is certific<br>director,  |                  | 25. Was case referred to medic examiner?   |   |   |                        | 26. Pla                                      | ice of Death (Chec           |                                 |                                     |                           | 7            |                         |
| <u>=</u>   | hysic<br>this ca  | 일                | 1 Yes 2 No   | Hospital:                                 | +   | ER/Outpatien           | t 3 DOA Other                                | r:<br>4  Nursing Ho          | ome 5 🗆 Resid                   | dence 6 🗆                           | Other (Specify            |              |                         |
| 0  | ding Phy<br>h.<br>After thi<br>funeral  | ate              | 27. Manner of Death  1 Autural 5 Per   | ding (A                                   | ate of injury<br>Month, Day, Year)                          | 28b. Time of<br>injury | 28c. Injury<br>work?                         | ,                            | 28d. Describe h                 | now injury occ                      | curred                    |              |                         |
| Siol   | death<br>death<br>ctor:<br>y the  | Certificate:     | 3 Suicide 6 Cou  | stigation<br>Id not be                    | ace of Injury - At h  | nome farm etre         | 750  | Yes 2 □ No                   | Off Leasting (6                 | Dave eat a med A for                | wahar as Direct           | Davida Alvia |                         |
| Σ  | al or A<br>s after<br>I Dire<br>d in b  |                  | 4 ☐ Homicide dete  | rmined 200. Fi                            | uilding, etc. (Speci  | fy)                    | et, factory, office                          |                              | 28f. Location (S<br>City or Tou |                                     | imber or Hurai            | moute ivun   | nper,                   |
|  | ospita<br>hours<br>ineral<br>ly fille   | Medical          | 29a. Certifier rtify   | ng Physician: To th                       | ne best of my know  | vledge, death o        | ccurred at the time,                         | , date and place, a          | and due to the ca               | ause(s) and m                       | nanner as state           | ed.          |                         |
|  | To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as | Med              | (Check Medical | I Examiner: On the<br>ng Lurse Practition | basis of examination  | on and/or investi      | gation, in my opinior<br>death conumed at th | n, death occurred a          | t the time, date a              | ind place, and<br>he cause(s) a     | due to the cau            | ise(s) and n | n <b>an</b> ner stated. |
|  | Voirt<br>Voirt<br>Com   |                  | 29b. Signature and title of celti  | fier                                      | my  |                        | 29c. License                                 | number                       |                                 | 29d. Date s                         | gned (Month, L            | Day, Year)   |                         |
|  |   |                  | 100  |   |   | <u> </u>               | 107  | 8000                         |                                 | <u> </u>                            | UH1                       | (1)          | 6                       |
|  | 10X1  |                  | 30. Name and address of person   |   |   | m 23a) (Type, P        | Z01  | House                        | tal A                           | ~ (a                                | en -                      | Ran          | me.                     |
|  | Stat  | 0                | 31. Date filed (Month, Day, Year   |   | 2. Registrar's Signa  | ature                  | 1.   | 11-011                       | , - / 0                         | -                                   | 1/                        |              | ,                       |
|  | Registra  |                  | MAY 0.9 2012   | Regues                                    | A. ba   | Made                   |  |                              |                                 |                                     |                           |              |                         |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ May 77 2012 7:45 A M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Heritage Harbour Health & Rehab. Annapolis If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Social Security Number **Funeral** Months Hours Min (Month, Day, Year) 204-16-0458 **Director** 1 🕱 M 2 🗆 F 84 1927 Pennsylvania June 11. 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2X No Columbia MD. Howard ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a USA 21044 10641 Gramercy Place #347 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: White "natural", 3 Widowed 4 X Divorced Year or Dates or other traumatic event, the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. Education Vice Principal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Kazimir Daniel Guydar Josephine 1 and 2 should be of Health and Meinten 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Steven Daniel/ Son 10641 Gramercy Place #347 Columbia, MD. 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Owings Mills, MD. 4 Donation 5 Other (Specify) 5-10-12 Garrison Forest\_VA 22. Name and Address of Facility on Funeral Home, 1050 York Rd. Towson, MD. Funeral Server e Liver see 21. Signature 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Itoria Physician/ resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or). Cause (Disease or injury that initiated events resulting in death) Last and -trar Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? has after death.

Director: After this certificate 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) funeral ( 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No Accident Suicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C completely filled Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mame and address of person who completed cause

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Ann Marie Puskarich Dobal 05 2012 5:18 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Funeral Months Days Hours 1 □ M 2 🔀 F Director 183-24-3366 70 09/25/1932 Illinois Usual Residence of Decedent show ms 23a or 28a-f sho must be notified at 10a, State 10b. County death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 5905 Grosvenor Lane 20814 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after 2 No Maryland 21215-0036 Yes 1 ☐ Yes 2 🕅 No Specify: If Yes, Give "natural" Specify 3 Widowed 4 Divorced Year or Dates White event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16h Kind of Rusiness Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Financial Secretary Public Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ traumatic Francis Puskarich Mary Milcic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Marci Ann Dobal /daughter 947 Powhatan Street, Alexandria, VA 22314 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 5/10/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 2 Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Severe Ulcerative Colitis Medical resulting in death) Due to (or as a consequence of) Examiner Gastrointestinal Bleeding Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a nonsequence of: or Attending Physician: The law requires that the death certificate be executed after death. physician and the burial-transit Anemia that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 signed by the attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>}</u> Pseudomonal Pneumonia Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛛 Unknown Completed pinous been Pulmonary Emboli 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed' Deep Venous Thrombosis 1 ☐ Yes 2 💢 No 1 ☐ Yes 2 😿 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 Tes X□ No Other: ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) 5 Pending 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0068160 May 7, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kimberly B. Zuzak, MD, 8600 Old Georgetown Rd Bethesda, MD 20814 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

MAY 0 9 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edison Robert Lee April 21, 4:45 A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Cheverly Prince Georges Hospital Center 8. Date of Birth (Month, Day, Year)1934 Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 1 Year **Funeral** Min Months **Director** 427-80-7968 78 1 **X** M 2 □ F January 28, Mississippi 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 No District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be with t Funeral 3005 Bladensburg Road, N.E.; Apt. 807 20018 United States within 72 hours after death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify **Black** "natural", 3 Widowed 4 Divorced Specify: Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 5th grade Construction Worker Construction Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ Edison Annie Mae Jones 19a. Informant's Name/Relationship (Type, Print) (Wife) permit. Page 1 and 2 st.
Department of Health an.
Important: If item 27 is m
any injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20009 Annie Pearl Gladley-Jefferson Edison; 1432 Girard Street, N.W.; Apt. D411; Washington, D.C. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 12°.2012 1 🗆 Burial 2 ី Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory, Inc. Beltsville, Maryland Funcial Service Licens 22. Name and Address of Facility R. N. Horton Company Morticians, **-cc**0333 Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line, rediate Cause (Final ase or condition Immediate Cause (Final Ph, sician disease or condition Medical resulting in death) Que,to (or as a consequence of) **Examiner** NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of HKOSTATE METASTATIC Exam that the death certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 SS IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death been signed by the a should be detached t Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 ☐ Yes 2 ☐ No Yes or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 2 X No Other: မ 1 Yes 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 X Natural 5 Pending injury after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifie 29c. License number 29d. Date soned (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) CUMBERBATCH. HOSPITAL CHEVERLY. MD MD

Registrar DHMH 17 Rev 06-2011

State

3001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 7:01 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 5. Social Security Number If Under 1 Year : If Under 24 Hrs. Date of Birth (Month, Day, Year) 06/02/1929 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ours Months Days Min. Country) Maryland 1 □ M 2 🎗 F Director 579-40-7170 Yrs 82 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26888 Mary Dixon Road 20659 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. Hygiene. other than "natural", or i Completed by 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify 3 - Widowed 4 X Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Meteorologist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental ည Joseph Colton Ellen Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Melody Suite / Daughter 26888 Mary Dixon Road, Mechanicsville, MD 20659 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Chesapeake Crematory 5/9/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall 1000 Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine consequence of burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Pregnant at time of death signed by the a d be detached f g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural
Acciden
Suicide 5 Pending work? 2 | No Accident Investigation 3 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse\*Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 reat

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

21412

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 14632 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ URF Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2811 Dunglen Court Dundalk Baltimore Funeral Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours (Month, Day, Year) 07/25/1938 Country) Maryland 1 X M 2 □ F Director 212-36-4655 73 r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 2811 Dunglen Court death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Narried Black, White, etc. δ Baltimore, Maryland 21215-0036 hours after ☐ Yes Yes, Give 2 No 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed Specify Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) within 72 Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) **Typesetter** Print permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If Item 27 is marked other any injury or other traumatic event, # 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unkn Unkn. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna J. Lyons / POA 2811 Dunglen Court, Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 5/8/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dor<u>ota Marhall 🗸</u> Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ OBSTRUCTIVE disease or condition resulting in death) HRONIC Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Other (specify) Pregnant at time of death Month 1 ∐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No 2 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D46360 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May Gloria Dorothea Forrester 2012 11:35 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Carroll Hospital Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Hours 219-30-6379 **Director** 1 🗆 M 2 🗶 F 77 January 10,193**5** Maryland or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Manchester 1 Yes 2 X No Maryland Carroll 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò ral", or items 23a or Examiner must be o Funeral 21102 United States 2724 Bachman Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Yes 2 X No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify. Completed 3 Widowed 4 X Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) administrative assistant hospital pharmacy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev Adele Burch |Frederick Gibmeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Forrester/daughter 2724 Bachman Rd. Manchester, MD 21102 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem GardMay 9, 2012 Timonium, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee John O. Mitchell IV, Funeral Services of Dulaney 200 E. Padonia Rd. Timonium, MD 21093 Valley, P.A. 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Onset and Death Physician/ Manic Shinataly disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transif Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? for 5 Other (specify) Month Day Pregnant at time of death Year signed by the at Id be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy has Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 3 H မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner o Peath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 atural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🚂 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) -0054218 ause of death (Item 23a) (Type, Print) 349 Malcolm dure, west minter

Registrar

31. Date filed (Month, Day, Y NAY 0 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19b.perFH, G927, 5714/2012, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ O 6 Day Month Year wood Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Takoma Montgomer Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 X M 2 D F Min. Months Days 241-58-8225 72 Yrs. Director NC Usual Residence of Decedent 28a-f show 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Woodlawn Balto 1 XYes 2 No ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 6806 enbern 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 and 2 should be filed within 72 hours after deal of Health and Mental Hygiene. iftem 27 is marked other than "natural", or iter other traumatic event, the Medical Examinen: Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ZNo Specify. Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be a Department of Health and Mental Important: If item 27 is many injury or other 2 Frink Lacewell rexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 380 Rd: Balto, MD 21207 Barbar Lenbern 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 🕾 Burial 2 🗆 Cremation 3 🗆 Removal from State Balto 05-4-12 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility James A-Morerowo Jones 1701 Laurens ST. Balta, MD 23a. Par . Enter the disease, or complications this caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Multipran failure
Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner Healthcare Asso. 1)20 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for as a consequence of: respirator -6 ת'ום and that initiated events Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical Box 68760 attending ph I for use as th IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 L 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed?
Yes 2 No has e 2 page certificate 1 Yes 2 No 25. Was case referred to medical **Division of Vital** funeral director, Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗹 No Hospital Other: 1 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗀 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of/certifier 29c License number 244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aven 600 MS 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Ralph Joseph Fogle May 03 2012 1:10 A<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2004 Letitia Avenue Baltimore 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min **Director** 220-38-9445 1 🛛 M 2 🗆 F 70 12/16/1941 Maryland Usual Residence of Decede 28a-f show 10a. State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 2004 Letitia Avenue 21230 U.S.A. death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify. Specify: Completed 3 Widowed 4 Divorced White Il Hygiene. other than "natura vent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Saw Operator Manufacturing and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Department of Health and Menta Important. If item 27 is marked any injury or other traumations. မ Ralph Sylvester Esther Fowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Pope / Daughter 1101 Turkey Hill Road, Vernon Hill, VA 24597 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🗀 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 🛮 Donation 5 🗆 Other (Specify) 05/07/2012 Anatomy Gifts Registry Hanover, Maryland 21. Signature of uneral Service L 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph ici n disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Die to for as a consecuence of: cause. Enter Underlying burial-transi or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death Yes 2 No be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 Yes 2 No Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: s after death. 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my k viedge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Da and address of person mpleted cause of death (Item 23a) (Type, Print) 0 LA 32. Registrar's Signa State 0 9 2012 Registrar

Physic Med Exam Funera Directo permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036 Physician Medica Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

|                                |  |   | Plea                                    | -                   | pe or Pri   |                  |                |   |                            |                           |                     |                                  |                 |                          | gible.                   |                                    |                     |
|--------------------------------|--|---|---|---------------------|---|------------------|----------------|---|----------------------------|---------------------------|---------------------|----------------------------------|-----------------|--------------------------|--------------------------|------------------------------------|---------------------|
|                                | 1  | For<br>State<br>Registrar   |   | •                   | State of M  | iaryiar          |                |   | ent of t                   |                           | and i               | vientai Hy                       | gien<br>Reg. N  | 21                       | 012                      | 14                                 | 636                 |
|                                |  | Decedent's Name   | e (First, Middle                        | e, Last)            |   |                  |                |   |                            |                           |                     | 2. Date of De                    | eath            |                          |                          | 3. Time of                         |                     |
| ian<br>Iica                    |  | Winston   | Ambros                                  | e Gay               | y, Jr.  |                  |                |   |                            |                           |                     | Month<br>5                       | ع               | ay                       | Year                     | 012                                | <b>5</b> M          |
| ine                            | r '  | 4a. Facility Name (if   |   |                     | et and number)  |                  |                |   | ity, Town, o               | r Location                | of Death            |                                  | 4               |                          | y of Death               |                                    |                     |
| 7                              | 5  | 17 Candy 5. Social Security No  |   | Lane<br>6. Sex      | 7. Ac   | je (In yrs. I    | ast birthday)  |   | rlin<br>der 1 Year         | If Under                  | r 24 Hrs.           | 8. Date of Bi                    | rth             | word                     | ceste                    | place (State or                    | r Foreian           |
| r                              |  | 213 78 4  | 408                                     | 1 X                 | M 2 □ F 54  |                  | Yrs.           | Month                                   | hs Days                    | Hours                     | Min.                | 10/7/1                           | 957             |                          | Country)                 |                                    |                     |
| ٦,                             |  | Usual Residence of<br>10a, State  |   |                     |   | 10c Cit          | y, Town or La  | ncation                                 |                            |                           |                     |                                  |                 |                          |                          | 10d. Inside Cit                    | y Limite            |
|                                | ecto   | MD  | Worce                                   |                     |   |                  | rlin           | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                            |                           |                     |                                  |                 |                          |                          | 1 🗆 Yes                            |                     |
|                                | 5  | 10e. Street and Nun   |   |                     |   |                  |                | 10f.                                    | Zip Code                   |                           |                     |                                  | 10g. C          | Citizen of               | What Cou                 | intry?                             |                     |
|                                | Funeral Director   | 17 Candy  | Tuft                                    | Lane                |   |                  |                |   | 21811                      |                           |                     |                                  | USA             | A                        |                          |                                    |                     |
|                                |  | 11, Marital Status  |   | 12.                 | Was Decedent<br>Armed Forces?                               |                  | S. 13.         | Was Ded<br>If Yes, sp                   | cedent of H<br>pecify Cuba | lispanic Or<br>an, Mexica | igin? (Spen, Puerto | ecify Yes or No-<br>Rican, etc.) | -               |                          | ce - Ameri<br>ck, White, | can Indian,                        |                     |
|                                | 0  | 3 Widowed   |   |                     | 1 Yes 2 If Yes, Give Year or Dates,                         | No               |                | 1 🗆 Yes                                 | s No                       | Specify                   | <i>r</i> :          |                                  |                 | Specify                  |                          |                                    |                     |
|                                | Completed by   | /C no   | 15. Deceder                             |                     | ation   |                  | 16a. Dece      | dent's U                                | Isual Occup                | ation                     |                     |                                  | 16b.            | Kind of B                | Business Ir              |                                    | -                   |
|                                | E  | Elementary/Seco   | cify o <i>nly highe</i><br>onday (0-12) | est grade t         | College (1-4 or   | 5+)              | life. L        | DO NOT                                  | work done<br>use retired)  |                           |                     |                                  |                 |                          |                          |                                    |                     |
|                                | ao⊢  |   |   | ( a a t)            |   |                  |                | auto                                    | part                       |                           |                     |                                  |                 |                          | otiv                     | e                                  |                     |
| 1                              | 0  |   |   |                     |   |                  |                |   |                            |                           |                     |                                  | e)              |                          |                          |                                    |                     |
|                                | ł  | 19a. Informant's Name/Relationship (Type, Print)  Linda J. Barnett (sister)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 109 Brunswick Lane Landenberg, PA 1935  20a. Method of Disposition  1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  All County Cremation 5-7-12  Sykesville |   |                     |   |                  |                |   |                            |                           |                     |                                  |                 | State Zin                | Code                     |                                    |                     |
|                                |  |   |   |                     |   |                  |                |   |                            |                           |                     |                                  |                 |                          | oode,                    |                                    |                     |
|                                | - 2  |   |   |                     |   |                  |                |   |                            |                           |                     |                                  |                 | - City or T              | own, State               |                                    |                     |
|                                |  |   |   |                     |   |                  |                |   |                            |                           |                     |                                  |                 |                          |                          |                                    |                     |
| 2                              | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & P.O. Box 195 Sykesville, MD 21784 |   |   |                     |   |                  |                |   |                            |                           |                     | Chapel                           |                 |                          |                          |                                    |                     |
|                                | $\dagger$  | 23a. Part 1. Enter t  | he disease, or                          | complica            | tions that cause  |                  |                |   |                            |                           |                     |                                  |                 | 2170                     | <u>.</u>                 | Approximate                        |                     |
| /                              |  | snock, or near<br>Immediate Cause (I<br>disease or conditio   | Final                                   | only one c          | ause on each lin  |                  | finfl          | ا<br>المعلاج                            | ha                         | ung ir                    | ) (A                |                                  |                 |                          |                          | Interval Betw<br>Onset and D       |                     |
| al                             |  | resulting in death)   |   | <b>a</b>            | Due to (or as   | a consequ        | uence of):     | 10100                                   | , ,,,,                     |                           | -                   |                                  |                 |                          | _                        |                                    |                     |
| ,                              | <u>.</u>   | Sequentially list con   | nditions,                               | b. •                | Durate (sure  |                  |                |   |                            |                           |                     |                                  |                 |                          | _                        |                                    |                     |
| Evaminor                       |  | if any, leading to im<br>cause. Enter Under<br>Cause (Disease or i  | rlying 🕵                                | (                   | Due to (or as   | a consequ        | uence ot):     |   |                            |                           |                     |                                  |                 |                          |                          |                                    |                     |
|                                |  | that initiated events<br>resulting in death) I  |   | С                   | Due to (or as   | a consequ        | uence of):     |   |                            |                           |                     | ·                                |                 |                          |                          |                                    |                     |
| Completed by Division (Medical |  |   |   | <b>L</b> d          |   |                  |                |   |                            |                           |                     |                                  |                 |                          |                          |                                    |                     |
| W                              |  | F FEMALE:   |   | 000                 | 16  |                  |                |   |                            |                           |                     |                                  |                 |                          |                          |                                    |                     |
| 20.00                          |  | 23b. Was decedent in the past 12 r  | nonths?                                 | 230.                | If yes, outcome  1  Live Birth  4  Pregnant a               | 2 Feta           | al death 3     |   | ic pregnand                | СУ                        |                     |                                  |                 |                          | ate of delivers          |                                    | ear                 |
| 10,14                          | Š L  | 1 Yes 2 9 Unknown   | J No                                    |                     | g 🗌 Unknown   |                  |                |   | (000011)/                  |                           |                     |                                  |                 |                          |                          |                                    |                     |
| 2                              | ל ל  | Part II. Other signif   | icant condition                         | o <b>ns</b> contril | buting to death b   | out not res      | sulting in the | underlyir                               | ng cause gi                | ven in Part               | : I <b>.</b>        | 23e. Did t                       | obacco          | use cont                 | tribute to t             | the cause of de                    | eath?               |
| 700                            | ם  | ·   |   |                     |   |                  |                |   |                            |                           |                     | 1 🗆                              | Yes 2           | 2 No                     | 3 Pro                    | obably 4 🗆 U                       | Jnknown             |
| 1 2 2                          |  |   |   |                     |   |                  | _              |   |                            |                           |                     | 24a. Was<br>auto                 | DSV             |                          | prior to co              | opsy findings a<br>ompletion of ca | vailable<br>luse of |
|                                |  | DF 14/  | . 14 111                                |                     |   |                  |                | -                                       |                            |                           |                     |                                  | ormed?<br>2 A 1 | No                       | death? 1 Yes             | 2 🗆 No                             |                     |
| á                              |  | 25. Was case referre<br>examiner?<br>1   ✓ Yes 2  | No Medical                              | Hos                 | pital:  |                  |                |   | Oth                        | lace of Dea               |                     |                                  |                 |                          |                          |                                    |                     |
| 12                             | 2 2  | 27. Manner of Death   |   |                     | 28a, Date of Inju   | irv              | ER/Outpatie    |   | 28c. Injur                 | 4 L N<br>yat              |                     | ome 5 X Resi<br>28d. Describe I  |                 |                          |                          | y)                                 |                     |
| 100                            | <u> </u>   | 1  Natural 2  Accident  | 5 Pendin                                | gation              | 5   5   12  | y, Yea <i>r)</i> | injury<br>OLCO | М                                       | work<br>1                  | Yes 2                     | .                   | Man                              |                 | 111                      |                          |                                    |                     |
| Ť                              | =  | 3 <b>X</b> Suicide<br>4  Homicide   | 6 ∐ Could<br>determ                     |                     | 28e. Place of Inj<br>building, et                           | c. (Specify      | 1)             | reet, fact                              | tory, office               |                           |                     | 28f. Location (                  | Street a        | n <i>d N</i> um <i>b</i> | er or Rura               |                                    |                     |
| 15                             | <u> </u>   | OOn Contilion 1   | Cardifician                             | Dhuniaia            | Les   | idenc            | <u>e</u>       |   |                            |                           |                     | 17 Cane                          |                 |                          |                          | Bellin M                           | <i>N</i> O          |
| Modioal Cortificato.           |  | 29a. Certifier 1<br>(Check 2<br>only one) 3   | Medical E                               | Examiner:           | n: To the best of<br>On the basis of e<br>ractioner: To the | examination      | n and/or inves | stigation,                              | in my opini                | on, death o               | ccurred a           | the time, date                   | and plac        | e, and du                | e to the ca              | ause(s) and man                    | ner stated.         |
| -                              |  |   | tle of costifier                        | r                   |   |                  | ,              | $\overline{}$                           | 29c. Licens                | e number                  |                     |                                  | 29d. D          | ate signe                | d (Month,                | Day, Year)                         |                     |
|                                |  | 1 (0  | lul                                     | ) !                 | DME   |                  |                |   | 1720                       | (PP                       |                     |                                  | 51              | 5/12                     | _                        |                                    |                     |
|                                | (  | 30. Name and address  | of of person                            | who comp            | oleted cause of c   |                  | 1 23a) (Type,  |   | . 8                        | Saks                      | bury                | , ть                             | 21              | 801                      |                          |                                    |                     |
| ate                            | 3  | 31. Date filed (Month   | h. Dav. Year)                           | 0-0                 | 32 Benistr  |                  | 1. 60          |   |                            |                           |                     |                                  |                 |                          |                          |                                    |                     |
| trar                           |  | N.  | AY 09                                   | 2012                | 12 min  | لا ما            | 7. 60          | Ma                                      |                            |                           |                     |                                  |                 |                          |                          |                                    |                     |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Physician/ 00 pm oze 20/2 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, **Funeral** Min 1 □ M 2 🔁 F NC Director 79 215-30-4886 Oct 17, 1932 Usual Residence of Deced ems 23a or 28a-f shov r must be notified at shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No **Baltimore** MD **Baltimore City** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with U.S.A. 20 South Catherine Street 21223 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify. Specify: Black "natural" Completed 3 ¥ Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) **Maryland Cup Corporation** Machine Operator 12 of Health and Mental Hygi item 27 is marked othe other traumatic event, i Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Laura Wilson Roger Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 South Catherine Street, Baltimore, MD 21223 **Dominic Gordon** 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State May 11, 2012 Owings Mills, Md. **Garrison Forest Veterans** 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) g physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☑No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 🗌 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examino? မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month. .Dav. Year) MO

DHMH 17 Rev 06-2011

State Registrar South

Name and address of person who completed cause of death (Item 23a) (Type, Print)

atherine

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 50RDOM 2:35P M 2012 05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1 Medical Anne under Center 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth **Funeral** (Month, Day, Year) Director 1 □ M 2 😿 F show 10c. City, Town or Location 10b. County 10a, State 10d. Inside City Limits notified at Director owie 28a-f 1 Tes 2 No 10f. Zip Code ms 23a or ō 10g. Citizen of What Country? Funeral MarTHA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: BLack Completed 3 X Widowed 4 Divorced of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 114 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. ClinTON, MD 4 Donation 5 Other (Specify) 420 H STIEET N.E. Signature of Funeral Service Licensee 22. Name and Address of Facility WasH., D.C., 20002 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final RIGHT BASAL Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any leading to in redictions. Enter Underlying Cause (Disease or injury Examiner Dun to for as a nonsequence of: signed by the attending physician and defacted for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been some the stand to the control of the contr Division of Vital Records, P.O. Box 68760 IF FEMALE: should be detached for use yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OA6ULOPATHT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of **Director:** After this certificate has d in by the funeral director, page 2 autopsy performe death? 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 🗌 Yes မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending filled in by the Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

Registrar DHMH 17 Rev 06-2011 med

Par

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DATEU

31. Date filed (Month, Day, Year)

0 9 2012

2001

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  |  |                | For   | State of M                             | aryland                        |                              | ırtment of H  |               | and Mei             | ntal Hyg                     | giene     |                |            | 1.1                           | c 0 C            |
|--|--|----------------|---|--|--------------------------------|------------------------------|---|---------------|---------------------|------------------------------|-----------|----------------|------------|-------------------------------|------------------|
|  |  |                | State Registrar   | 11                                     |                                | Cer                          | tificate of D   | eath          |                     |                              | Reg. No   | 20             | 12         | 14                            | 635              |
|  | Physicia   | ın/ °          | 1. Decedent's Name (First, Middle, Las  | ,                                      |                                |                              |   |               |                     | Date of Dea<br>Month         | th<br>Day | y Ye           | ear        | 3. Time of                    |                  |
|  | Medic  |                | Richard Joseph Gr 4a. Facility Name (if not institution, give   |  |                                |                              | 4b. City, Town, or  | Location      |                     | May                          | <u>6</u>  | 201            |            | 11:2                          | 0 P <sup>™</sup> |
| Harri  | Examin   | er             | Patuxent River He   | ,                                      | hah                            |                              | Laurel  | Location      | or Death            |                              |           | County of      |            |                               |                  |
|  | Funeral  |                | 5. Social Security Number 6. Se   | x 7. Ag                                | e (In yrs. last                | birthday)                    | If Under 1 Year   | If Under      |                     | Date of Birth                | 1         | rince          |            | rge 's                        | r Foreign        |
|  | Director   |                | 112-22-0591   | <b>X</b> M 2 □ F                       | 81                             | Yrs.                         | Months Days   | Hours         | Min.<br>Ma          | (Month, Day,<br>arch 9       | Year)     |                | Countr     | y)<br>York                    |                  |
|  | d<br>iow   | L              | Usual Residence of Decedent  10a, State  10b, County  |  | 100 City T                     | Town or Loc                  | otion   |               |                     |                              |           |                | Lin        |                               |                  |
|  | arylan<br>a-f sh<br>fied a   | Director       |   |  |                                |                              | ation   |               |                     |                              |           |                | 10         | d. Inside Cit                 |                  |
|  | or 28  | <u></u>        | MD Prince G  10e. Street and Number   | eorge's                                | Laur                           | cer                          | 10f. Zip Code   |               |                     | 7                            | 10a Cit   | izen of Wha    | at County  |                               | - XIVO           |
|  | with the 23a (23a)   | era            | 9010 Briarcroft L   | ano 7n+                                | 200                            |                              | 20708   |               |                     |                              | USA       | 12011 01 44116 | at Octanii | y:                            |                  |
|  | eath y   | Funeral        | 11. Marital Status  | 12. Was Decedent 8                     |                                | 13. W                        | as Decedent of His  | spanic Orig   | gin? (Specify       | Yes or No-                   |           | 14. Race -     | America    | n Indian,                     | -                |
| 9  | fter d<br>, or i   | ρ              | 1 Never Married 2 🔀 Married   | Armed Forces? 1 ☐ Yes 2 🏋 If Yes, Give | No                             |                              | Yes, specify Cubar  ☐ Yes 2 🔀 No                              |               |                     | an, etc.)                    |           |                | White, et  |                               |                  |
| 21215-0036   | ours a<br>tural'<br>al Ex  | Completed      | 3 Widowed 4 Divorced  | Year or Dates.                         |                                |                              |   |               |                     |                              |           | Specify: V     | White      | е                             |                  |
| 45   | 72 hc<br>n "na<br>fedic  | lg l           | 15. Decedent's Ed<br>(Specify only highest gra  | ucation<br>de co <i>mpleted)</i>       |                                | (Give k                      | ent's Usual Occupa<br>ind of work done do<br>NOT use retired) |               | t of working        |                              | 16b. Ki   | ind of Busin   | ess Indu   | istry                         |                  |
| 712  | /ithin<br>iene.<br>r tha   | ပ္ပြဲ          | Elementary/Seconday (0-12)  | College (1-4 or 5                      | ·                              | Manaq                        | · · · · · · · · · · · · · · · · · · ·                         |               |                     |                              | Res       | staura         | ant.       |                               |                  |
| b  | iled v<br>Il Hyg<br>othe<br>vent,  | Be             | 17. Father's Name (First, Middle, Last)   |  |                                | Manag                        | CI  | 18. Mothe     | er's Name (Fi       | rst, Middle, I               |           |                |            |                               |                  |
| /lar   | d be f<br>Aenta<br>arked<br>itic e   | 욘              | Emil Grasmuck   |  |                                |                              |   | Hele          | n Silv              | estro                        |           |                |            |                               |                  |
| Maryland   | should<br>and I<br>is ma   |                | 19a. Informant's Name/Relationship (Ty  | oe, Print)                             |                                | 19b. Mailin                  | g Address (Street a   | nd Numbe      | er or Rural Ro      | oute Number,                 | City or   | Town, State    | e, Zip Co  | de)                           |                  |
| ≥  | nd 2<br>lealth<br>m 27<br>her tr   |                | Elizabeth Grasmuc   | k / wife                               |                                |                              | Briarcro  | ft Ļn         | , #309              | , Lau                        | rel,      | MD 2           | 20708      | 3                             |                  |
| OFF  | ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at   |                | 20a. Method of Disposition 1 ☐ Burial 2 ※ Cremation 3 ☐   | Removal from State                     |                                | ce of Dispos<br>netery, crem | sition (Name of<br>atory or other place                       | 9)            | Date                | ·                            | 20c. Lc   | ocation - Cit  | ty or Tow  | n, State                      |                  |
| Baltimore,   | it. Pag<br>rtmen<br>rtant<br>rjury   |                | 4 ☐ Donation 15 ☐ Other (Specif)  | )                                      | West                           |                              | del Crem  |               | 5/9/20              |                              |           | nton,          |            |                               |                  |
| Ba   | permit. Page 1 a Department of I Important: If ite any injury or ot  |                | 21. Signature of uneral Service Livens  |  | M01581                         | 22.                          | Name and Addres 3 Talbott                                     | s of Facility | y Donal             | ldson :                      | Fune      | eral H         | Iome       | P.A.                          |                  |
|  |  |                | 23a. Part 1. Eriter the disease, or comp  | lications that caused                  | d the death. [                 |                              |   |               |                     |                              |           | 707            |            | Approximate                   | 9                |
| shock, or heart failure. List only one cause on each line.  Immediate Cause (Final |  |                |   |  |                                |                              |   |               |                     |                              |           |                |            | nterval Bety<br>Onset and D   | veen             |
|  | Medical  |                | disease or condition resulting in death)  | a. Cardii<br>Due to (or as             | a consequen                    | ice of :                     |   |               |                     |                              |           |                | -          |                               |                  |
|  | Examiner   | L              | Sequentially list conditions  | h                                      |                                |                              |   |               |                     |                              |           |                |            |                               |                  |
|  | - ±  | ine            | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying |  |                                |                              |   |               |                     |                              |           |                |            |                               |                  |
|  | and<br>trans   | xan            |   | c. Due to (or as:                      | a consequen                    | oo of:                       |   |               |                     |                              |           |                | 1          |                               |                  |
| _  | ate be executed<br>bhysician and<br>the burial-transit   | dical Examiner | resulting in death) Last  | Due to (or as                          | a consequen                    | ice oi).                     |   |               |                     |                              |           |                |            |                               |                  |
| 760  | phys<br>phys<br>s the l  | ledic          | _   | d                                      |                                |                              |   |               |                     |                              |           |                |            |                               |                  |
| Box 687  | eath certifice<br>attending p  | n/M            | IF FEMALE:<br>23b. Was decedent pregnant  | 3c. If yes, outcome                    | of pregnancy                   | у П                          |   |               |                     |                              |           | 23d. Date o    | f deliven  | ,                             |                  |
| Š  | death<br>e atte  | sicia          | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4 Pregnant a                           | 2 L. Fetal de<br>t time of dea | th 5                         | Ectopic pregnancy<br>Other (specify)                          | /             |                     |                              |           | Month          |            |                               | 'ear             |
| P.O.   | es that the dea<br>signed by the a<br>I be detached f  | Physician/Me   | g 🗌 Unknown   | 9 Unknown                              |                                |                              |   |               | - 1                 |                              |           |                |            |                               |                  |
| <u>.</u>   | s thai<br>igned<br>be de   | by             | Part II. Other significant conditions co  | ntributing to death b                  | out not resulti                | ing in the ur                | nderlying cause give  | en in Part I  | . ]                 |                              |           |                |            | cause of de                   |                  |
| rds  | requires<br>been signification   | eted           |   |  |                                |                              | · · · · · · · · · · · · · · · · · · ·                         |               |                     | 1 ⊔ Y                        | es 2 l    | _ No 3 l       | _ Proba    | bly 4 🛛 L                     | Jnknown          |
| 000  | law r<br>has b<br>le 2 sh  | Completed by   |   |  |                                |                              |   |               |                     | 24a. Was a autops perform    | sy        |                | r to com   | y findings a<br>pletion of ca |                  |
| ž  | sician: The law is certificate has t   | ပိ             | 25. Was case referred to medical  |  |                                |                              |   |               |                     | 1 Yes                        |           |                | Yes 2      | □No                           |                  |
| /ita   | sicial<br>s certi<br>lirecto   | To Be          | evaminer?   | lospital:                              | ent 2 ER                       | VO. 44:4                     | Other   | r             | th (Check onl       |                              |           |                |            |                               |                  |
| of/  | g Phy<br>er this<br>neral c  |                | 27. Manner of Death   | 28a. Date of inju                      | ry 28                          | 3b. Time of                  | 28c. Injury   | at            | irsing Home<br>28d. | Describe ho                  |           |                | specity)   |                               |                  |
| on   | ath.<br>ath.<br>ir: Aft  | ficat          | 1 X Natural 5 Pending<br>2 Accident Investigation   | (Month, Day                            | y, rear)                       | injury                       | M 1 🗆 v   | yes 2 🗆       | No                  |                              |           |                |            |                               |                  |
| Division of Vital Records,   | l or Atte<br>after de<br>Directo   | Certificate:   | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined  | 28e. Place of Injubuilding, etc        |                                | e, farm, stre                | et, factory, office   |               | 28f.                | Location (St<br>City or Town |           | Number o       | r Rural R  | oute Numbe                    | er,              |
| Ö  | pital o  |                | On Our A Plants B   |  |                                |                              |   |               |                     |                              |           |                |            |                               |                  |
|  | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit  | Medical        | 29a. Certifier 1 X Certifying Phys<br>(Check 2 Medical Examinonly one) 3 Certifying Nurs                            | er: On the basis of e                  | xamination ar                  | nd/or investi                | gation, in my opinior   | n, death oc   | curred at the       | time, date an                | d place,  | and due to     | the caus   | e(s) and mar                  | ner stated.      |
|  | Vithin To the To the To the Complete Co | 2              | 29b. Signature and title of certifier   | e Fractioner. To the                   | Dest Of Hig Kr                 | iowieage, a                  | 29c. License  | -             | and place, ar       |                              |           | e signed (M    | . 6        | iy, Year)                     |                  |
|  |  |                | > mhre  |  | M                              | ·D.                          | N   | ST.           | 013                 |                              |           | 5              | 8          | 12                            |                  |
|  |  |                | 30. Name and address of person who co   | ompleted cause of d                    | eath (Item 23                  | Ba) (Type, Pr                | int)  | , ce          | aih                 | 1 2                          | 04        | 1              |            |                               |                  |
|  | 71   |                | 31. Date filed (Month, Day, Year)   | ev970/e                                | X O                            | VIVE                         | - 111   | [[2]          | OTT                 | 1 ~                          | NUH       |                |            |                               |                  |
|  | Stat<br>Registra   |                | MAY 0 9 2012  | 32. Hegistra                           | ar's Signature                 | back                         |   |               |                     | _                            |           |                |            |                               |                  |
|  |  |                | MHI O O FAIR  | 1                                      | -                              |                              |   |               |                     |                              |           |                |            |                               |                  |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Veal **Physician** Godfrey 7:39 A M Julia 28 2012 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 09/06/1971 5. Social Security Number 6 Sex 7. Age (In vrs. last birthdav) **Funeral** 1 🗆 M 2 🗆 🛣 Days 213-80-5353 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location 1 ∏ Xes 2 ☐ No Director MD Baltimore the Medical Examiner must be notified 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Numbe 2709 Grindon Ave. 21214 **USA** Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Xio Black White etc. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 2 □ **X**o 1 Tyes þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Bookkeeper Insurance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Tom Godfrey Julia Owen ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: if Item 27 Is any Injury or other trauonce. Alvin Lightman / Husband 2709 Grindon Ave., Baltimore, MD 21214 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory 5/2/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Marshell 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final embolism **Physician** Pulmonary disease or condition resulting in death) Due to (or as a unsequence of): /Medical Examiner Suspected deep true to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami The law requires that the death certificate be executed attending physician and I for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Live birth 2 Fetal death Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the att 1 Yes 2 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 certificate has 1 ☐ Yes 2 No 1 Tyes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital: 1 Minpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3 🗆 DOA 5 ☐ Residence 6 ☐ Other (Specify) ၉ After this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the funeral Certification: 5 Pending investigation Injury 1 Natural 1 🗌 Yes 2 | No 2 Accident eral Director: / 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined 4 Homicide 24 hours 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contifier

51

State Registrar

DHMH 17 Rev 1/2001

bares

MD, MAH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD, MPH

Ahmed,

Haitham

31. Date filed (Month, Day, Year)

RES-000

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6ert MAY  $04^{3}$ 20 12 01:18A Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death **MONTGOMERY** ROCKVILI E 10217 DAPHNEY HOUSE WAY Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 💢 M 2 🗆 F 190-24-9377 0271571928 Director 84 POLAND. Usual Residence of Decedent 10c. City, Town or Location ROCKVILLE ms 23a or 28a-f shov must be notified at 10a. State 10h Count with the Maryland 10d. Inside City Limits Director MONTGOMERY 1 Yes 2 No 10f. Zip Code 20850 10e. Street and Number 10g. Citizen of What Country? Funeral 10217 DAPHNEY HOUSE WAY USA Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status "natural", or iten edical Examiner 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 WHITE 1 Yes 2XXNo Specify: 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) th and Mental Hygiene.
7 is marked other then Elementary/Seconday (0-12) College (1-4 or 5+) **CLERK** GROCER Y Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental F fitem 27 is marked or r other traumatic ever ပ SHEPETINSKY SHIFRAH AHARON GOLTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10217 DAPHNEY HOUSE WAY, ROCKVILLE, MD 20850 MIRIAM COHEN/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla SHAARE TORAH CEM. 20c. Location - City or Town, State Department of H Important; If ite any injury or oth Date 1 N Burial 2 Cremation 3 N Removal from State 4 Donation 5 D Other (Specify) 05/06/2012 PITTSBURGH, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused shock, or heartfailure. List only one cause on each line Immediate Cause (final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) CCII 4 CGIS Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate

Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 1 ☐ Yes ≥ L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manne eath Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical etrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) m D 35103 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., STEPHEN VACCAREZZA, 6240 MONTROSE ROAD, ROCKVILLE, MD 20852 32. Registr State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY <sup>Day</sup> 2012 DR. RONALD PHILLIPS HAIRSTON 10:41 AM Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Director 290-32-3085 76 1 🕅 M 2 🗆 F APRIL 1 1936 OHIO Usual Residence of Decedent shov with the Maryland 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits 28a-f 1 Yes 2 □ No MD ANNE ARUNDEL ANNAPOLIS Ö 10e. Street and Number ö ritems 23a or ner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 512 DUVALL LANE 21403 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner I 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 X No If Yes, Give Year or Dates. Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. BLACK 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) PHYSICIAN Ith and Mental Hygie 27 is marked other r traumatic event, the PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ODELL HAIRSTON ELZINA PHILLIPS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 BARBARA BROWN HAIRSTON/WIFE 512 DUVALL LANE ANNAPOLIS, MARYLAND 21403 other 1 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) LINCOLN CEMETERY 5/14/2012 SUITLAND, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 lane 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition m Medical resulting in death) Due to (or as a conseque **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami the burlal-transit Cause (Disease of it that initiated events and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical certificate be Box 68760 as attending IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year Yes 2 No the 9 Unknown 9 Unknown P.0. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this ce completely filled in by the funeral dire 2 HNo ည ER/Outpatient 3 DOA Inpatient 2 🗌 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 02-03-9013 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Par

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death (AKA) Betty Gumpper Hocker Physician/ Month SARA ELIZABETH GUMPPER HOCKER 2012 10:45A Medical May 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS Baltimore County Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Hours **Director** 214-18-3561 1 🗆 M 2 💢 F 101 Aug 23, 1910 Pennsylvania show 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County Timonium 1 Tes 2 X No 10e. Street and Number 10g, Citizen of What Country? Funeral 300 Dulaney Valley Road 21093 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Own Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Alfred Jacob Gumpper Annie Laurie Wilson other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.0</u> Carole L. McCrory (Daughter) 11508 Pebblecreek Drive, Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State Druid Ridge Cemetery 5/9/2012 4 Donation 5 Other (Specify)
21. Sign We of Foot Start Services Pikesville, Maryland MITCHECL WIEDEFELD FUNERAL HOME, INCMartin D. Lawson 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Dementi Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes No \_\_ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, Director: After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending injury work? 1 \( \subseteq \text{Yes} 2 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who coppleted cause of death (Item 23a) (Type, Print)

Registrar

State

TRACIE MORGAN, CRNP

NAY 0 9 2012

10:05

HOCKER

 $BET^{\prime}TY$ 

32. Registrar's Signature

2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 2133 PM Wendel Henry Apr 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 257-78-1000 Director 1 M 2 D F 4-20-144 South Catalinia 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Md Baltimore 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21201 Funeral 1027 Catheral Street USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. Specify: BLack If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) Camden YARds College (1-4 or 5+) Youse Kec Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) 2 UKn UKn permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code) ChardRA Anderson Balto. Md. 21237 esaco Ave 730 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview CREMAYERY 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 12 Cremation Removal from State Balto. Md. -9-12 4 Donation 5 Other (Specify 22. Name and Address of acility 21. Signat 2/2/3 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ 1 diopathic disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the at Id be detached for a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed 1 ☐ Yes 2 ☑ No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 2 🔽 No 1 🛮 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certificate: 28c. Injury at iniury work?
1 ☐ Yes 2 ☐ No 5 Pending 1 🗹 Natural Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Wine D72344 April 30, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21201 Ismail South Greene Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 9 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Lillian B. Hughes Physician/ 7:21AM  $\mathcal{M}_{A}^{\circ}$ 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Glen Burnie Baltimore Washington Medical Ctr. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea 8/21/1925 Days Hours Min 219-18-6987 **Director** 1 M 2 XF Maryland 86 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location Medical Examiner must be notified at 10d Inside City Limits Director MD Dundalk 1 Yes 2 X No Baltimore or. 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21222 United States 444 Westfield Road "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces Black, White, etc. Yes 2 X No Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: ¾☐ Widowed 4 ☐ Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Bag Company 7 Years Printer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Josephine Bystry Joseph Ruszkiewicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21061 Patricia Ann Clark (Niece) 503 Kintop Road Glen Burnie, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem.Gdns5/5/2012 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servic Pensee M1 chael Neiser <sup>22 Name and Address of Facility</sup>
Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physiotec Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to jor as a consequence of Due to (or as a consequence of): resulting in death) Last physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? 4 Pregnant at time of death 9 Unknown Month Day 1 Yes 2 Unknown be detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ fo the Hospital or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed death? certificate 2 **N**o Yes 2 N 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 No Accident Investigation

Division of Vital Records, P.O. Box 68760

hin 24 hours after death. the Funeral Director: After filled in by completely

2

Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 00

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

6 Could not be

determined

Suicide

4 Homicide

29a. Certifier

ss of person who completed cause of death (Item 23a) (Type, Print) MUGION erbatu

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

|             | Box 6876                |
|-------------|-------------------------|
|             | Box                     |
| PES         | P.O.                    |
| EARL HOOPES | ision of Vital Records, |
| ы           | Vital                   |
|             | of                      |
|             | vision                  |

|            |  |                   |   | Please   | Type or Pr   |                            |                               |   |                               |             | •                |   | _egible.                         |  |
|------------|--|-------------------|---|--|--|----------------------------|-------------------------------|---|-------------------------------|-------------|------------------|---|----------------------------------|--|
|            |  |                   | For<br>State  |  | State of M   | laryland                   |                               | artment of F<br><i>tificate of D</i>                            |                               | and M       | -                | _   | 2012                             | 11.61.6  |
|            |  |                   | Registrar  1. Decedent's Nam  | e (First, Middle, Last   | )  |                            | Cel                           | - Lincale Of L  |                               |             | 2. Date of De    |   | 2012                             | 3. Time of Death                                   |
|            | Physicia<br>Medic  |                   | Farl  | _  | J.   |                            |                               | Hoopes,   | Jr.                           |             | Month<br>05      | 05<br>Day                                 | 2012                             | 03:00 a <sup>M</sup>                               |
|            | Examin   |                   |   | f not institution, give s  | street and number)   |                            |                               | 4b. City, Town, or  |                               |             |                  |   | ounty of Death                   |  |
|            | Funeral  |                   | Stella Mar  5. Social Security N  | ris Hospice umber 6. Se  | x 7. A   | ge (In yrs. la.            | st birthday)                  | Luthervil<br>If Under 1 Year                                    | If Under                      | 24 Hrs.     | 8. Date of Bir   | th  |                                  | hplace (State or Foreign                           |
|            | Director   |                   | 220-20-684  |  | <b>Z</b> M 2 □ F   | 84                         | Yrs.                          | Months Days   | Hours                         | Min.        |                  | (Month, Day, Year) Country) 03/16/1928 MD |                                  |  |
| -          | ind<br>show<br>at  | or                | Usual Residence   | of Decedent  10b. County   |  | 10c. City,                 | Town or Lo                    | cation  |                               |             | 03/10/.          | 1920                                      |                                  | 10d. Inside City Limits                            |
|            | Maryla<br>28a-f s<br>otified   | Director          | MD  | Baltimo  | re   | Park                       | wille                         |   |                               |             |                  |   |                                  | 1 🗆 Yes 2 🕱 No                                     |
|            | th the   | al Di             | 10e. Street and Nur   | mber   |  |                            |                               | 10f. Zip Code   |                               |             |                  | -   | en of What Co                    | untry?   |
|            | 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.  Ithem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at   | Funeral           | 9200 Avon   | dale Road  | 12. Was Decedent   | Ever in U.S.               | 13. \                         | 21234<br>Was Decedent of H                                      | ispanic Orio                  | ain? (Spe   |                  | U.S.A.                                    | . Race - Amer                    | ican Indian  |
| စ္တ        | fter de<br>, or its  | þ                 |   | ried 2 ื Married   | Armed Forces?  | No                         |                               | f Yes, specify Cuba<br>1 ☐ Yes 2 🛣 No                           | n, Mexican                    | i, Puerto I | Rićan, etc.)     |   | Black, White                     |  |
| 21215-0036 | ours af<br>ntural"<br>al Exe   | Completed         | 3 Widowed   | 4 Divorced   | If Yes, Give<br>Year or Dates.                               | 1948-52                    | <u>'</u>                      |   |                               |             |                  |   | becify: Whi                      |  |
| 715        | ה 72 ho<br>an "na<br>Medio   | mple              |   | ecify only highest grade   |  | 5.1)                       | (Give                         | dent's Usual Occup<br>kind of work done o<br>O NOT use retired) | during most                   | t of workir | ng               |   | d of Business/I                  |  |
|            | l withii<br>ygiene<br>her th<br>t, the   |                   | Elementary/Sec<br>1   |  | 4  | 51)                        | Engine                        | er  |                               |             |                  | Co  | nstruc                           | tion   |
| and        | oe filed<br>ntal Hy<br>ced oth<br>cevent   | To Be             | 17. Father's Name   | _  |  | Ш                          | C-                            |   |                               |             | (First, Middle,  | Maiden Su                                 |                                  | ouchat   |
| Maryland   | should be file and Mental P is marked o raumatic eve   |                   | Earl 19a. Informant's N   | Jay<br>ame/Relationship (Ty)   | oe, Print)   | пос                        | pes, Si                       | ng Address (Street a  | Marga:<br>and Numbe           |             | Route Numbe      | er, City or To                            |                                  |  |
|            | and 2 sh<br>Health a<br>em 27 is<br>ther tra   |                   | Theresa Ho  | oopes, Wife  |  |                            | 9200                          | Avondale R  | oad, P                        | arkvi       | lle, MD 2        | 21234                                     |                                  |  |
| Baltimore, | Page 1 and<br>ment of Hea<br>ant: If item<br>ury or other  |                   |   | Cremation 3  |  |                            | ace of Dispo<br>emetery, crer | sition (Name of<br>natory or other plac                         | e)                            |             | ate              | ŀ   | ation - City or                  |  |
| Iţi        | 2 4 4 5  | 3                 |   | 5 Other (Specify   |  | Loud                       | -                             | Cemetery  Name and Addres                                       | es of Facilit                 |             | 9/2012           |   | more, M                          |  |
| Ba         | permit<br>Depar<br>Impor<br>any in   |                   | ) Q   | exandu   | a Bl   | aù                         |                               | 5305 Harfor   |                               |             |                  |   | ick, Inc.<br>4                   |  |
| -          | Try ician<br>Medical   |                   | 23a. Part 1. Enter shock, or hea Immediate Cause disease or condition resulting in death) |  | e cause on each lir<br>a. <b>LUNG</b> (                      | ie.<br>CANCER              | <b>L</b>                      | er the mode of dyin   | g, such as                    | cardiac o   | respiratory ar   | rrest,                                    |                                  | Approximate<br>Interval Between<br>Onset and Death |
| Start.     | Examiner   |                   | ,   | r  | Due to (or as  | a conseque                 | ence of):                     |   |                               |             |                  |   |                                  |  |
|            | *  | iner              | Sequentially list con<br>in any, leading to in<br>cause. Enter Unde                       | onditions,   | b. Jule to (or th  | a nonsequi                 | orien offr                    |   | _                             |             |                  |   |                                  | -  |
| œ          | executed<br>an and<br>rial-transit   | Examiner          | Cause (Disease or<br>that initiated event<br>resulting in death)                          | injury<br>ts   | c. Due to (or as   | a conseque                 | ence off:                     |   |                               |             |                  |   |                                  |  |
|            | is as  |                   | resulting in deatiny  |  | d.   |                            |                               |   |                               |             |                  |   |                                  |  |
| 68760      | ifficate<br>ng phy<br>as the   | Medi              | IF FEMALE:  |  | u  |                            |                               |   |                               |             |                  |   |                                  |  |
| Box 6      | To the Hospital or Attending Physician: The law requires that the death certificate be within E4 hours after death certificate has been signed by the attending physicii To the E4 hourstal Director. After this certificate has been signed by the attending physicii completely filled in by the funeral director, page 2 should be detached for use as the bu | Physician/Medical | 23b. Was decedent in the past 12 1 Yes 2 9 Unknown  | months?  | 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown | 2 🔲 Fetal<br>at time of de | death 3                       | Ectopic pregnand Other (specify)                                | Ç <b>y</b>                    |             |                  | 23  | d. Date of deli<br>Month         | ivery<br>Day Year                                  |
| ds, P.O.   | quires that the series and signed by sould be deta   | ted by Pł         | Part II. Other signi  | ficant conditions co   | ntributing to death  | but not resu               | ılting in the u               | underlying cause giv  | ven in Part                   | l.          |                  |   | contribute to                    | the cause of death?                                |
| Records,   | : The law re<br>cate has be<br>r, page 2 sh  | Completed by      |   |  |  |                            |                               |   |                               |             |                  |   | prior to death?                  | copsy findings available completion of cause of    |
| of Vital   | sician<br>certifi<br>lirectol  | To Be             | 25. Was case referr<br>examiner?<br>1 ☐ Yes 2   | -  | Hospital:  | tiont 2 🗆 I                | EP/Outpation                  | 26. Pl  | ace of Dear                   |             |                  | C TV                                      | 7 Other (Case)                   | fy) HOSPICE  |
| of         | ng Phy<br>ter this<br>neral o  |                   | 27. Manner of Deat  | th _   | 28a. Date of inj   | ury                        | 28b. Time of injury           |   | y at                          |             | 28d. Describe I  |   |                                  | ny HOSI ICE  |
| ion        | tendin<br>leath.<br>:or: Aff<br>the fu   | Certificate:      | 1 X Natural 2 Accident 3 Suicide  | <ul> <li>5 ☐ Pending</li> <li>Investigation</li> <li>6 ☐ Could not be</li> </ul> |  |                            |                               | M 1 🗆   | Yes 2                         | _           |                  |   |                                  |  |
| Division   | oital or Attending Ph<br>urs after death.<br>rral Director. After th<br>illed in by the funeral  |                   | 4  Homicide   | determined   | building, e  | tc. (Specify)              |                               | eet, factory, office  |                               |             | City or Tov      | wn, State)                                |                                  | al Route Number,                                   |
|            | the Hosp<br>thin 24 ho<br>the Fune<br>mpletely i   | Medical           | (Check 2<br>only one)   | Medical Examing X Certifying Nurs  |  | examination                | and/or inves                  | tigation, in my opinio<br>, death occurred at t                 | on, death och<br>the time, da | ccurred at  | the time, date a | and place, a<br>the cause(s)              | nd due to the c<br>and manner as | cause(s) and manner stated.<br>s stated.           |
|            | <b>7</b> ≥ 6 8   |                   | 29b. Signature and  | My   | an   | SNF                        | NE                            | 29c. Licens   | 130                           | 22          | 72               | 5   | signed (Mor)th                   | 1 2  |
|            | 1041   |                   |   | ress of person who c   |  |                            |                               | Print)<br><b>EY VALLEY</b>                                      | RD.                           | TTM         | ONIUM,           | MD 21                                     | 1093                             |  |
|            | Sta<br>Registra  |                   | 31. Date filed (Mon   | th, Day, Year)   | -  | mer'e Signatu              |                               |   |                               |             | on Long          | .w <i>L</i> .                             | -0//                             |  |
| Divi       | * 1  |                   | 3   |  |  | _4                         |                               |   |                               |             |                  |   |                                  | ·  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death 2409 Manning Avenue Baltimore Co. Edgemere Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Hours (Month, Day, Year) 219-12-9092 Director 1 - M 2 1 F 94 Dec. 25,1917 Virginia Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health end Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Edgemere Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2409 Manning Ave. 21219 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mamie Alsie Snow Asberry Decatur Snow, Sr. 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Margaret Harlow In Law Essex, Maryland 020 Beach Road 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ot
once. 20c. Location - City or Town, State cemetery, crematory or other 1 A Burial 2 Cremation 3 Removal from State 5/10/2012 4 Donation 5 Other (Specify) Holly Memorial Gdns. Quinque, VA 21. Signature of Funeral Service Licensee Mark W1111ams 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician CEREBROVASCULAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was dece 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Day g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No Yes 2 IN the funeral director, 25. Was case referred to medical a 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 1 Yes 2 No ျှ HOMO 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 0 SM address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

Date filed (Month, Day, Year)

0 9 2012

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| ichard Hoopert   |                              | 1- For State  | e of Maryla                         |  | partment of<br><i>ertificate</i> of |  | d Mental        | -                      | 2                     | 012                          | 1464                  |
|--|------------------------------|---|-------------------------------------|--|-------------------------------------|--|-----------------|------------------------|-----------------------|------------------------------|-----------------------|
| Physicia   |                              | Registrar<br>1. Decedent's Name (First, Middle,L  | ast)                                |  | -                                   |  |                 | 2. Date of Dea         | ath                   | 3.                           | Time of Death         |
| ledical Examin   | er                           |   | Richa                               |  | Ноор                                |  |                 | Month<br>May 1, 20     |                       |                              | 2335 hrs              |
| 1  |                              | 4a. Facility Name (if not institution, g<br>2209 Pulaski Highway                                      | jive street and nun                 | nber)  | 4                                   | b. City, Town, or<br>Harford             | Location of De  | ath                    | 4c. County of Harford | f Death                      |                       |
| Funeral  |                              |   | Sex :                               | 7. Age (In yr                                | s. last birthday)                   | If Under 1 Year                          | If Under 24H    | Irs. 8 Date of Bi      | rth (MM/DD/YYYY)      | 9. Birthola                  | ace (State or         |
| Director   |                              |   | X M 2 F                             |  | Yrs.                                | Months Days                              |                 | 1in.                   |                       | Foreign<br>Country           |                       |
|  | ŀ                            | Usual Residence of Decedent   | 201                                 | 36   |                                     |  |                 | May 21                 | 1,19/5                | 0.00                         | N MD                  |
| hu k   |                              | 10a. State 10b. County  |                                     |  | ity, Town or Locati                 |  |                 |                        |                       |                              | d. Inside City Limits |
| Maryland<br>28a-f show<br>1 at once.   | គ្ន                          |   | Baltimor                            | e  |                                     |  | dalk            |                        |                       |                              | Yes 2 No              |
| e Mary   | Director                     | 10e. Street and Number  |                                     | _  |                                     | 10f. Zip Code                            | 01000           | 1                      | log. Citizen of Wh    | •                            |                       |
| ith th   |                              | 7709 Old Battl  11. Marital Status  | e Grove                             |  | 11 S 13 M/a                         | Decadent of His                          | 21222           | Specify Yes or No      | United                |                              | es<br>Indian, Black,  |
| eath w   | Funeral                      | 1 X Never Married 2 Marrie  | ed Armed For                        | rces?  | If Ye                               | es, specify Cuban                        | , Mexican, Pue  | rto Rican, etc.)       | White                 |                              | Indian, Black,        |
| after d  | 1 Yes 2 No Specify: Specify: |   |                                     |  |                                     |  |                 |                        |                       |                              | White                 |
| hours<br>natur<br>Exami  | eted t                       | 15. Decedent's Education (Specify   | only highest grade                  | e completed)                                 |                                     | 's Usual Occupat<br>est of working life. |                 |                        | 16b. Kind of Bus      | siness/Indus                 | stry                  |
| 36 in 72 han "dical]   | 흶                            | Elementary/Secondary (0-12)   | College (1-                         | -4 or 5+)                                    | Labo                                |  |                 | ,                      | Cons                  | tructi                       | ion                   |
| 5-0036<br>iled within 7<br>Hygiene.<br>d other than  | Comple                       | 12 Years 17. Father's Name (First, Middle, La   | st)                                 |  | Labo                                |  | 18.Mother's Na  | me (First, Middle, I   | Maiden Surname)       | LIUCE.                       |                       |
| 215<br>be file<br>ntal H   | 8                            | Richard Alber   | t Hooper                            | t  |                                     |  | She             | rry Colle              | een Noona             | an                           |                       |
| hould hould is man   | 의                            | 19a. Informant's Name/Relationship  |                                     |  |                                     |  |                 |                        | nber, City or Towr    |                              |                       |
| Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic event, the Medical Examiner must be notified at once                       |                              | Mrs. Sherry Ho 20a. Method of Disposition   | opert (M                            |  | b. Place of Disposi                 |  |                 | Date Date              | Dundalk               |                              | 21222                 |
| Baltimore, permit. Pages 1 ar Department of Hee Important: If iten njury or other tr   |                              | 1 XBurial 2 Cremation   | _                                   | m State                                      | crematory or oth                    | er place)                                |                 |                        |                       | •                            |                       |
| Itim<br>it. Pa<br>urtmen<br>primit   | ŀ                            | 4 Donation 5 Other Speci  |                                     |  | Sacred Ht                           |  |                 |                        | 1                     |                              |                       |
| Depr.  | 1                            | 21. Signature of Funeral Service Lic  | Scott                               | P. Ga  | ardner Du                           | da-Ruck                                  | Funera.         | l Home of<br>Jundalk.N | f Dundall<br>Marvland | 2122<br>2122                 | c.<br>22              |
| Physician  | T                            | 23a. Part I. Enter the disease, or cor<br>failure. List only one cause on                             | nplications that care               | used the dea                                 | ath. Do not enter th                | e mode of dying,                         | such as cardia  | or respiratory arr     | est, shock, or hea    |                              | pproximate Interval   |
| /Medical<br>Examiner   | -                            | Immediate Cause (Final disease  | a. Mixed d                          |  | toxicatio                           | n (Heroi                                 | n,Alpra         | zolam& M               | leth <b>ado</b> ne    |                              | Death                 |
|  | -                            | or condition resulting in death)  | Due to (or as a                     | consequence                                  | e of):                              |  |                 |                        |                       |                              |                       |
|  | ē                            | Sequentially list conditions, if any leading to immediate   | Due to (or as a c                   | conséquenn                                   | e of):                              |  |                 |                        |                       | - 01                         |                       |
|  | Examiner                     | cause. Enter Underlying Cause<br>(Disease or injury that initiated<br>events resulting in death) Last | c.<br>Due to (or as a o             | consequence                                  | e of):                              |  |                 |                        |                       | _                            |                       |
| cuted<br>nd<br>transit   |                              | CVCITG TCSGITTING III CCGITTY LGST  | d.                                  |  | •                                   |  |                 |                        |                       |                              |                       |
| be executed isician and urial - transi   | dica                         | X UNPENDED  | AMENDED 2                           | 3a,27  | ,28a-f,pe                           | r me,g92                                 | 27 5–11         | -12 sm                 |                       |                              |                       |
| cath certificate be attending physic for use as the bu   |                              | IF FEMALE:<br>23b. Was decedent pregnant in the   | 23c. If yes, or                     |  |                                     |  | Tetopia         |                        | 23d. Date of o        |                              | V                     |
| Box 6876C death certificate the attending physed for use as the b  | Clar                         | past 12 months?   | 4 Pregna                            | int at time of                               | death                               | aldeath 3 [<br>er(Specify)               | Ectopic preg    | nancy                  | Month                 | Day                          | Year                  |
| BO<br>te deat<br>the at  | Physician/Me                 | 1 Yes 2 No 9 Unknow   | 9 ОПКЛОУ                            |  |                                     |  |                 |                        |                       |                              |                       |
| ires that the signed by  | 2                            | Part II. Other significant conditions   | <ul> <li>contributing to</li> </ul> | death but no                                 | ot resulting in the ur              | nderlying cause g                        | ven in Part I.  |                        | bacco use contrib     | _                            |                       |
| ords, I  | <b>B</b>                     |   | -                                   |  |                                     |  | <del> </del>    | - 24a. Was             |                       |                              | y findings available  |
| taw re has be  | Completed                    | <del></del>   |                                     | <u>.                                    </u> | <del></del>                         |  |                 | autop                  | sy pr                 |                              | letion of cause of    |
| tal Rec  |                              | 25. Was case referred to medical  |                                     |  |                                     | 26 Place                                 | of Death (Chec  | 1 Yes                  | 2 No 1                | <b>✓</b> Yes                 | 2 No                  |
| Vita<br>ysician<br>his cer<br>direct   | <u>m</u>                     | examiner? 1 ✓ Yes 2 No  | Hospital: 1 In                      | patient 2                                    | ER/Outpatient                       |  | <u> </u>        | <del></del>            | Residence 6           | Other: Sce                   | ene                   |
| ing Ph   | 의                            | 27. Manner of Death   | 28a. Date o                         | of Injury<br>Day,Year)                       | 28b. Time of In                     | jury 28c. Injur                          | y at Work?      | 28d. Describe I        | how injury occurre    | d                            |                       |
| ttendi<br>death.<br>ctor:  | ;                            | Natural 5 Pending Accident Investiga  | fd 5-                               |  | fd 11:3                             | 5 pm. ¹□ Y                               | es 2 🗶 No       | unknown                |                       |                              |                       |
| Division of Vital Records, P.O tal or Attending Physician: The law requires that treather death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaated in the funeral director, page 2 should be detaated.   | Certification:               | 3 Suicide 6 X Could no determin   | ot be                               |  | t home, farm, street                | , factory, office bi                     | uilding, etc.   | or Town, S             | state) 2209 I         | r or Rural R<br><b>ulask</b> | toute Number, City    |
| Lospital of thours a wineral I   | ဒီ -                         | 29a. Certifier  | (оросилу)                           |  | edge, death occurr                  | ad at the time da                        | to and place of | Edgewood               |                       | as stated                    |                       |
| Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b | Medical                      | (Check only 1 ☐ Certifying Physical Examin  |                                     | f examination                                |                                     |  |                 |                        |                       |                              | use(s)                |
| ¥.2 ¥.8  | ₽ŀ                           | 29b. Signature and title of certifier   | and manner Sta                      | atou.  |                                     | 29c. License                             | number          |                        | 29d. Date signe       | d (Month, £                  | Day, Year)            |
|  |                              | Hamel Fruit   | all, my                             | Ĵ  |                                     | O.C.N                                    | M.E.            |                        | May 2, 2012           | 2                            |                       |
| $\emptyset$  | Ī                            | 30. Name and address of person who  |                                     | ,  | · ·                                 | \A/ Paltiman                             | Street D        | Himara 14D C           | 1000                  |                              |                       |
| Y Ste  | fe                           | Pamela E. Southall, MD  31. Date filed (Month, Day, Year)   | Assistant M                         | jistrar's Sign                               |                                     | vv. Daiumore                             | - Sueet, Ba     | timore, MD 2           | 1223                  |                              |                       |
| Registr  |                              | MAY 0 9 2012 1  | mal B                               |  | that                                |  |                 |                        |                       | <u> </u>                     |                       |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                                |   |                 | for<br>State<br>Registrar   | State of Maryla  |  | artment of I<br>tificate of I                                  |  |   | ene<br>eg. No. 201  | 2 14649  |
|--------------------------------|---|-----------------|---|--|--|--|--|---|---|--|
|                                | Physicia<br>Medic   |                 | 1. Decedent's Name (First, Middle, Last   | HOL  | LAN  | 10   |  | 2. Date of Death                            |   | 3. Time of Death                                   |
|                                | Examir  | er              | 4a. Facility Name (if not institution, give s<br>1508 N. Smallwo  | ,  |  | 4b. City, Town, o Balti  | r Location of Death                                    | ,   | 4c. County of De  | eath   |
|                                | Funeral<br>Director   | Г               | 5. Social Security Number 6. Se.  |  | s. last birthday)<br>Yrs.                        | If Under 1 Year<br>Months Days                                 | If Under 24 Hrs.<br>Hours Min.                         | 8. Date of Birth<br>(Month, Day,<br>04-16-2 | 9.1   | Birthplace (State or Foreign Country)              |
|                                | ryland<br>-f show<br>ied at   | ctor            | 10a. State 10b. County  | 10c.   | City, Town or Loc                                |  |  |   |   | 10d. Inside City Limits                            |
|                                | the Mai<br>or 28a<br>e notifi   | I Director      | MD NA  10e. Street and Number   |  | Daitill  | 10f. Zip Code  |  | 11  | 0g. Citizen of What   | 1 XXYes 2 □ No Country?                            |
|                                | ath with  | Funeral         | 1508 N. Smallwoo  | od Street  12. Was Decedent Ever in  | II C. Ido V                                      | 212  |  |   | USA   |  |
| 9000                           | e filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at   | þ               | 1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced  | Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.                                   | lf.  | Vas Decedent of H  | ispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify: | eciry resion No-                            | 14. Race - American Indian,<br>Black, White, etc. Africa<br>Specify: American |  |
| 215-                           | n 72 ho<br>e.<br>an "nat<br>Medica  | Completed       | 15. Decedent's Ed<br>(Specify only highest grad   | de completed)  | (Give k  | ent's Usual Occup<br>kind of work done (<br>D NOT use retired) | ation<br>during most of work                           | ing   | 16b. Kind of Busines  | ss/Industry  |
| d 21                           | filed within al Hygiene. d other tha  | Be Co           | Elementary/Secondary (0-12)<br>8th Grade<br>17. Father's Name (First, Middle, Last)   | College (1-4 or 5+)  | Do   | mestic   | 40 Marks and Ministra                                  | - (5)-1-1-1-1-1                             | Home mal  | ker  |
| ylan                           | should be file<br>and Mental  <br>7 is marked or<br>raumatic eve  | To I            | Wilkes  | Smith  |  |  | Ada  | ne (First, Middle, Ma                       | aiden Surname)<br>Smith   |  |
| , Mar                          |   | Ų               | 19a. Informant's Name/Relationship (Type<br>Linda Clark-Daug  |  | 19b. Mailin<br>2548                              | g Address (Street a<br>W. LaFay                                | and Number or Rur<br>ette Avei                         | al Route Number, C<br>nue Balti             | City or Town, State,<br>More, Man   | zip Code)<br>Cyland 21216                          |
| Baltimore, Maryland 21215-0036 | permit. Page 1 and in Department of Healt Important: If item 2 any injury or other once.  |                 | 20a. Method of Disposition  1 Hugh Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,  | Removal from State   | o. Place of Dispos<br>cemetery, crem<br>Mt. Zion | sition (Name of<br>natory or other place<br>n Cem.             | o5 <b>-1</b> .   | I .   | 20c. Location - City<br>Lansdowne   |  |
| Balt                           | permit<br>Depart<br>Import<br>any inj<br>once.  |                 | 21. Signature of Funeral Service License  | · ston   |  | Name and Addres  |  |   | more. Man   | e P.A.<br>cyland 21217                             |
|                                | Physician/  | 2 2             | 23a. Part 1. Enter the disease, or compl<br>shock, or heart failure. List only on<br>Immediate Cause (Final<br>disease or condition | e cause on each line.  | eath. Do not ente                                | r the mode of dyin   |  | or respiratory arres                        | t,  | Approximate<br>Interval Between<br>Onset and Death |
|                                | Medical<br>Examiner   |                 | resulting in death)   | Due to (or as a cons   |  |  |  |   |   |  |
|                                | ed<br>nsit  | miner           | Sequentially list conditions, Language Course, Cause, Enter Underlying Cause (Disease or injury                                     | Due to (or as a cons   | oque de oij:                                     |  |  |   |   |  |
| 0                              | icate be executed physician and sthe burial-transit   | edical Examiner | that initiated events<br>resulting in death) Last   | Due to (or as a conse  | equence of):                                     |  |  | ***   |   |  |
| 68760                          | rtificate<br>ling phy<br>e as the   | /Medi           | IF FEMALE:  | 0. 16  |  |  |  |   | 1   |  |
| ). Box (                       | To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi | Physician/M     | 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown   | 3c. If yes, outcome of preg<br>1  Live Birth 2 Fe<br>4 Pregnant at time of<br>9 Unknown    | etal death 3 🗌                                   | Ectopic pregnance<br>Other (specify)                           | У  |   | 23d. Date of o  | lelivery<br>Day Year                               |
| ds, P.O.                       | requires that the death of been signed by the atter should be detached for  | by              | Part II. Other significant conditions con   | ntributing to death but not  | resulting in the ur                              | nderlying cause giv  | ven in Part I.   | 23e. Did toba                               |   | to the cause of death?                             |
| Recor                          | nysician; The law re<br>nis certificate has be<br>I director, page 2 sh   | Completed       |   |  |  |  |  | 24a. Was an autopsy perform                 | ed? prior to  | utopsy findings available completion of cause of   |
| Vital                          | /sician;<br>s certifi   | To Be           | 25. Was case referred to medical examiner?  1  Yes 2 No   | ospital:   | ☐ EB/Outpation                                   | Otho   | ace of Death (Chec                                     |   | ce 6 Other (Spe   | · ·  |
| Division of Vital Records,     | ending Physeath. or; After this contractions the funeral disperse   | Certificate: T  | 27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation   | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of injury                              | 28c. injury<br>work  | at at  | 28d. Describe how                           |   | certy)   |
| Divis                          | ital or Att<br>ins after d<br>al Direct<br>led in by  |                 | 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of Injury - At building, etc. (Spec   | home, farm, stree                                | et, factory, office  |  | 28f. Location (Stre<br>City or Town,        | et and Number or R<br>State)  | ural Route Number,                                 |
|                                | To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the  | Medical         | (Check 2 Medical Examination only one) 3 Certifying Nurse   | cian: To the best of my kno<br>er: On the basis of examina<br>Practitioner: To the best of | tion and/or investi                              | gation, in my opinio   | <ul> <li>n. death occurred a</li> </ul>                | the time, date and                          | place, and due to the   | cause(s) and manner stated                         |
|                                | Sor With  |                 | 29b. Signature and title of certifier   | Both   | -  | 29c. License   |  |   | d. Date signed (Mon   |  |
|                                | 29  |                 | 30. Name and address of person who co   | mpleted cause of death (It   | em 234 (Type, Pr                                 | int) L'an  | Blud   | afon  | Buenip  | 2012   |
|                                | Stat<br>Registra  |                 | AT e (led M 2012), Year)  | 32. R gistrar's sig  | nature   |  |  |   |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 14650 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 2012 5:13 p<sup>M</sup> Clifton Hartridge Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 8 6 Social Security Number irti م, Day, 6 Birthplace (State or Foreign Country) 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Days Min. Hours Director 82 Yrs ″1′9°30 230-40-0834 1 x M 2 🗆 F Danville,VA Usual Residence of Deced 28a-f show ms 23a or 28a-f shormust be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director DC Washington 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1363 Peabody Street NW #108 20011 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 Married Specify Black 1 ☐ Yes 2 No Specify: "natural", Completed 3 X Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Je filed with. Teal Hygiene. Ser than "r (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the 12yrs. Meter Tech DC Water Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H ဂ္ Ernest Hartridge Margaret Ferrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Gracie M. Gilliam/Niece 703 Othman Drive Fort Washington MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō Ξ 1 K Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) Mount Olivet Cemetery 5-11-2012 | Washington DC Signature of Funeral Service Lice 22. Name and Address of Facility John T. Rhines Funeral Home 23a. Part 1. Enter the disease, or complections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. 3005 12th Street NE Washington DC 20017 Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Kidney Failure Medical Due to (or as a consequence of) Examiner Diabetes Mellitus Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury and -tran Hypertension that initiated events resulting in death) Last ng physician ar Physician/Medical death certificate be use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year the b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has performed? Yes 2 K No this certificate 2 No 1 🗌 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 X Yes Other: 2 No 2 1 Inpatient 2 K ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🖾 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c. License number May 1, 2012 D0067427

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

George Ho.MD

31. Date filed (Month, Day, Year)

7600 Carroll Ave., Takoma Park, MD 20912

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ am Janice Horton Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death maryland General Baltemore N/A 9. Birthplace (State or Foreign f Under 1 Year If Under 24 Hrs. (In vrs. last birthday) Date of Birth **Funeral** 219-26-7128 Days Hours Min. 1 M 2 X F 049494939 73 Director Usual Residence of Deceden 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Anne Arundel Glen Burnie 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 93 Mary Lane Apt 102 B 21060 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ō 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. should be filed within 72 hours afti and Mental Hygiene. is marked other than "natural", Specify: Black 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 10th Grade College (1-4 or 5+) NSA Supervision Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Otho Horton unk 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Garston Ct. Apt F, Cockeysville, MD 21030 Latanya Anderson(daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State King Memorial Cem 05/09/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 308 PMATS OF BETOWN Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician OROnary disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury (or as a consequence of) Exami TERUSCIEROSi that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Vaai Day Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? Yes 2 death? certificate 1 Yes 2 No the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner\_of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 🗌 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide within 24 hours after death

To the Funeral Director: /
completed filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Maryland Gieneral Hospital 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 31. Date filed (Mont , ay, Year)

DHMH 17 Fev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>012</u> Physician/ 26, 4:10 A M Lee Harden Mary April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Lanham 7014 Wood Thrush Drive 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Min (Month, Day, Year) 421-72-4770 Director 1 □ M 2 🗓 F Yrs May 29, 1948 Alabama Usual Residence of Deceden items 23a or 28a-f show ier must be notified at 10d. Inside City Limits filed within 72 hours after death with the Maryland al Hygiene. 10a. State 10b. County 10c. City. Town or Location Director 1 X Yes 2 No Lanham Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 U.S.A. 7014 Wood Thrush Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates nan "natural", Medical Exa Specify: 3 X Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the College 12 Maid Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H 27 is marked of r traumatic even ည Ossie Simmons James Casey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh nt of Health a : If item 27 is or other trau 1711 8th St. N.W. #303 Washington, DC 20001 (Daughter) LaKeisha Harden Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Department of Important: If i any injury or conce. 1 🕅 Borian 2 🗆 Cremation 3 🗆 Removal from State 5/5/2012 Florence, AL Mt. Zion Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, VA Signature of uneral Service L censes Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer of Uterus disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Day Month Year Pregnant at time of death Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: X Natural 5 Pending 1 Yes 2 No neral Director: A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) > Jocelyne Kouatchou, m) 163748 April 26, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Jocelyne Kouatchou, M.D.

9 2012

31. Date filed (Month, Day, Yea

4041 Powder Mill Rd., Calverton, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 14653 Mitchell Harrell Certificate of Death 1. For State Reg. No. 3. Time of Death Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1606 hrs May 3, 2012 Mitchell A. Harrell "sal Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Sinai Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number oreian **Funeral** Months Country) 217-78-2359 Director MD 1 X M 2 F 51 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10b County Yes 2 No 23a or 28a-f shows notified at once. 28a-f show Baltimore MD death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21215 USA 3318 Hayward Ave. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11 Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 y No 1 Yes Specify: Black 1 Yes 2 X No specify: permit, Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", on injury or other traumatic event, the Medical Examiner. If Yes, Give Yeer 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 3 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore City Waste & Treatment MD 21215-0036 12th 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Geneva Ridenhour Oscar Lee Harrell Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 3318 Hayward Ave. Balto, Md. (sister) Vernel Harrell 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State May 12,2012 Balto, Md. King Mem Pk. 4 Donation 5 Other Specify 2 Name and Address of Facility Calvin B. Scruggs Funeral Home ature of Funeral S 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or hear 21213 Approximate Interval een Onset and Physician failure. List only one cause on each line Death Alcohol and Narcotic Intoxication /Medical Immediate Cause (Final disease ≟xaminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and cal AMENDED 23a, pt. II, 27, 28a-f, per me, g928 6-4-12 sm **X** UNPENDED g physician the burial -Physician/Medi 23d. Date of deliven requires that the death certificate be 23c. If yes, outcome of pregnancy Box 68760. IF FEMALE: Month Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the 2 Fetal death 1 Live birth been signed by the attending hould be detached for use as past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ≥ Cirrhosis of Liver; Chronic Alcoholism 24b. Were autopsy findings available Completed 24a. Was an page 2 should prior to completion of cause of autopsy death? performed? certificate has 1 Yes 2 No Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, of Vital B Other: Nursing Home 5 Residence 6 Other: Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 DOA 1 🗸 Yes 2 No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a, Date of Injury 27. Manner of Death unknown Certification: 1 Yes 2 No 1 Natural Pending fd 3:18 pm Division fd 5-3-12 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3318 Haywood Ave. Baltimore, MD. Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be 3 Suicide (Specify) Found: Residence determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 4, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner Ling Li, MD gistrar's Signature State

**ORIGINAL** 

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BROADRIDGE LANE **IITHERVILLE** RALTIMORE 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours 09/27/1922 219-16-8834 Director 1 ☐ M 2**X Y** F 89 POLAND or then "natural", or itams 23a or 28a-f sho the Wedical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours efter death with the Maryland Director LUTHERVILLE 1 🗌 Yes 2 💢 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6 BROADRIDGE LANE 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 Married 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed 3XXWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) CLERK STATE OF MARYLAND Be permit. Page 1 end 2 should be filed Ospartment of Health and Mental Hy Important: If Item 27 is merked oth any linjuy or other traumatic event ODG. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAM KEIL BESSIE SCHNEIDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 BROADRIDGE LANE, LUTHERVILLE, MD 21093 ARLENE GEARE/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BACTIMORE HEBREW CEM: 05/06/2012 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ REWAL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Day to for as a consequence of: Exami the burlal-transit or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): is certificate has been signed by the attending physicien director, page 2 should be detached for use as the burla Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 Other (specify) Month Day Year 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown PERIPHERAL VASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 2 No 2/ 1 Yes Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 유 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death,

To the Funeral Director: After this
completely filled in by the funeral of 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospitel Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the i only one) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) MAY 0 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY G927 5/09/2012 JH State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 5:52A M Physician/ 26,201 Eliza Jordan March Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4108 Coleman Avenue Baltimore 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) South **Funeral** Months Davs Hours Director 251-54-6073 1 M 2 XF 76 29,1935 Yrs July Carolina Usual Residence of Decedent 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a. State Director ms 23a or 28a-f s must be notified N/A Baltimore 1X Yes 2 □ No Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral USA 21205 Street McElderry 2321 items be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Examiner Yes, specify Cuban, Mexican. Puerto Rican. etc. Armed Forces? Black, White, etc. 5 1 X Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify Black If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced 16b.Kind of Business/Industry
Baltimore City
Hospital Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Enviromental Services 6th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F ဂ Hattie Brown Manford Jordan and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4108 Coleman Ave.Baltimore, Md. 21213 item 27 Lorraine Pulliam/Daughter other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Carmel Cemetery Department of Important: If it any injury or o permit, Page 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03-30-12 Dundalk, Maryland Mt.Carmel 4 ☐ Donation 5 ☐ Other (Specify) Road Parking FuneralHome 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4210 Belair Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner CO CN Cegae, itially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir as the burial-tran and that initiated events Due to (or as a consequence of resulting in death) Last attending physician Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed 2 🗌 No 1 Yes Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be Daughter's WResidence examiner? Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence XX Other (Spec 28b. Time of . Injury at work? 1 ☐ Yes 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28c. 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After Natural injury 5 Pendina 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0 30. Name and address of person who combleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 9

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day **JONES** DERRICK 2012 12:10 P M Medical MAY 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death UPPER MARLBORO PRINCE GEORGE'S 17105 CLAIRFIELD LANE 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 159-40-8490 Country) **Director** 1 M M 2 □ F Usual Residence of Decedent APRIL 5 1950 PENNSYLVANIA or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director PRINCE GEORGE'S UPPER MARLBORO 1X Yes 2 No 10e. Street and Number 5 items 23a or ner must be n 10g. Citizen of What Country? Funeral 17105 CLAIRFIELD LANE 20772 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status er than "natural", or ite the Medical Examiner 14 Race - American Indian þ 1 X Never Married 2 Married Black, White etc. 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) TEACHER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental F ည HAYWOOD C. JONES II VIVIAN L. MILLS other traumatic and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 113 NINA DRIVE #101 VIRGINIA BEACH, VIRGINIA 23462 TIMIKO BLACKMAN/DGT Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 20c. Location - City or Town, State o .\_\_ Date Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) RIVERDALE CREMATORY 5/14/2012 RIVERDALE, MARYLAND Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ MYOCARDIAL INFARCTION disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner CONGESTIVE HEART FAILURE Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury MITRAL REGURGITATION burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 phys the L as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ for in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death Yes 2 L Unknown the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performed?

1 Yes 2 XNo certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death. e Funeral Director: A pletely filled in by the fi Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) MAY 8, 2012 D46065 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 V

DHMH 17 Rev 06-2011

State Registrar NADER DAKAK M.D.

MAY 0 9 2012

31. Date filed (Month, Day, Year)

32. Registrar's Signature

12150 ANNAPOLIS ROAD #105 GLENN DALE, MARYLAND 20769

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Physician/ MARUON LOUISE JORDAN 12:00N M MAY Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Baltimore Future Care -Cherrywood N.H. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Birthpia Country) VA. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Sept. 2,1919 Months Days Hours Min **Director** 214-14-5146 Usual Residence of Decedent 1 M 2**X X**F 92 28a-f show 10d. Inside City Limits Oa. State 10b. Count 10c. City, Town or Location Injury or other traumatic event, the Medical Examiner must be notified at Director Baltimore County Baltimore Maryland 1 Yes 2XXNo or. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 21236 4106 Slater Avenue or items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 2XXNo 1 Yes If Yes, Give Maryland 21215-0036 White 1 Yes 2XXNo Specify: Specify: "natural", 3 ☒ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene, is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) N/A Restaurant 7 yrs. Hostess Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 1 and 2 should be find Health and Mental fitem 27 is marked James Delano Martha Maxi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1818 Briarcliff Rd. Baltimore, Md. 21234 Mary lou Jones (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Moreland Mem. Pk. 5-10-2012 Baltimore, Md. Lassahn Funeral Home Name and Address of Facility ture of Funeral Service Licensee 7401 Belair Rd. Baltimore, Maryland 21236 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ leavs disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or injury that initiated events the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23d. Date of delivery Physician/ 23b. Was decedent pregnant past 12 months?

1 Yes 2 No
9 Unknown Month Year Day the by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed t þ Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ANo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performe 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 🛣 No To the Hospital or Attending Physiolan: "
within 24 hours after death.

To the Funeral Director, After this certifica completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4

✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 1, 2012 737573 gn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Battimore MO 2835 ZIDEN MD Ave 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

|                     |   |                              |  | Please                            | Type or Pri   |                                      |                             |                              |                  |                         |                          | •                       | _  | bie.                        |   |
|---------------------|---|------------------------------|--|-----------------------------------|---|--------------------------------------|-----------------------------|------------------------------|------------------|-------------------------|--------------------------|-------------------------|--|-----------------------------|---|
|                     |   |                              | For<br>State   |                                   | State of M  | laryland                             |                             |                              |                  |                         | d Mental                 | Hygie                   | ene 21   | 112                         | 14658                                   |
|                     |   |                              | Registrar  | m                                 | -41   |                                      | Cer                         | tificate o                   | of D             | eath                    |                          |                         | g. No.   | 716                         |   |
|                     | Physicia<br>Medic   | al.                          |  | ROTH                              | /   |                                      | Joi                         | ves                          |                  |                         | Mon                      |                         | 1 A 2012 1030 PM   |                             |   |
| 1                   | Examin  | er                           |  | not institution, give             | street and number)  |                                      |                             | 4b. City, Tow<br>Tows        |                  | _ocation of De          | eath                     | •                       | 46. County of Death Baltimore                                      |                             |   |
| ~~~                 | Funeral   |                              | 5. Social Security No  |                                   |   | ge (In yrs. las                      | t birthday)                 | If Under 1 Y                 | ear [            | If Under 24 H           | Irs. 8. Date             | of Birth                | · ·  |                             | ace (State or Foreign                   |
|                     | Director  |                              | 212 28 5<br>Usual Residence  | Carried Control (Alle)            | □ M 2 □XX   | 82                                   | Yrs.                        | Months D                     | ays              | Hours M                 | lin. Octo                | th, Day, Y<br>ober 2    | 21, 1929   |                             | imore,Maryland                          |
|                     | show  | 호                            | 10a. State   | 10b. County                       |   | 10c. City, Town or Location          |                             |                              |                  |                         |                          |                         | 10d. Inside City Limits  |                             |   |
|                     | Mary  | Director                     | Maryland   | Baltimore                         | 9   | Balt                                 | imore (                     | County                       |                  |                         |                          |                         |  |                             | 1 ☐ Yes 2 XXNo                          |
|                     | ith the   | ralD                         | 10e. Street and Nun  | nber<br>enezer Road               |   |                                      |                             | 10f. Zip Co<br>212           |                  |                         |                          | 10                      | ng. Citizen of W<br><b>USA</b>                                     |                             | ry?                                     |
|                     | ems ?   | Funeral                      | 11. Marital Status   | Hezer Hodu                        | 12. Was Decedent  |                                      | 13. V                       | Vas Decedent                 | of His           | panic Origin?           | (Specify Yes             | or No-                  |  |                             | an Indian.                              |
| 980                 | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23a or 28a-f show entry injury or other treumatic event, the Medical Examinar must be rutilized at once. | Completed by F               | _  | ied 2 🗆 XMarried<br>4 🗆 Divorced  | Armed Forces?  1  Yes 2  If Yes, Give Year or Dates.                        | 1 Yes 2 Who Specify:                 |                             |                              |                  |                         | èrto Rican, et           | c.)                     | No- 14. Race - American Indian, Black, White, etc.  Specify: White |                             |   |
| 5-0                 | "netu   | plet                         | (Spe   | 15. Decedent's E                  |   | - 1                                  | 16a. Deced                  | dent's Usual O               | ccupat           | tion<br>uring most of v | vorkina                  | - 1                     | 6b. Kind of Bu   | siness/Ind                  | ustry                                   |
| 121                 | thin 7  | l o                          | Elementary/Seco  | ondary (0-12)                     | College (1-4 or<br>N/A  | 5+)                                  | life. D                     | O NOT use ret<br>istrative   | ired)            | •                       | •                        |                         | CCBC Es  | sex                         |   |
| d 2                 | ed wi<br>Hygie<br>other<br>ent, tr  | Be                           | 17. Father's Name (  |                                   | IV/ A   |                                      | Auturn                      | LSCHALLIVE                   |                  |                         | Name (First. M           |                         | iden Surname   |                             |   |
| Maryland 21215-0036 | uld be fil<br>Mental<br>narked<br>natic ev  | 잍                            |  | łudolph Wund                      |   |                                      |                             |                              |                  | Katheri                 | ine Marga                | aret K                  | íraft  |                             |   |
| , Mar               | nd 2 shou<br>ealth and<br>m 27 is n   |                              | 19a. Informant's Na<br>Michael   | C Jones (F                        | Type, Print)<br>Husband)  |                                      | 19b. Mailir<br>4416         | ng Address (St<br>Ebeneze)   | reet ar<br>Ro    | ad Number or<br>ad Bal  | Rural Route I<br>Limore, | Mary]                   | ity or Town, St<br>Land 2123                                       | ate, Zip Ci<br>6            | ode)                                    |
| Baltimore,          | Page 1 a<br>lent of H<br>nt: If ite<br>ry or oth  |                              |  |                                   | Removal from State  | cernetery, crematory or other place) |                             |                              |                  |                         |                          |                         |  | ation - City or Town, State |   |
| Balti               | permit. F<br>Departm<br>Importa<br>eny inju   |                              | 21. Signature of Fu  |                                   | <u> </u>  | )                                    |                             | 2. Name and A                | Fun              | of Facility<br>eral Hon | ne Inc                   |                         |  |                             |   |
|                     |   | Н                            | 23a, Part 1, Enter t   | the disease, or com               | plications that cause   | d the death.                         | Do not ente                 |                              |                  |                         |                          |                         | ryland 21<br>t   |                             | Approximate                             |
|                     | nysician/   |                              | shock, or heal<br>Immediate Cause (  | rt failure. List only o<br>(Final | one cause on each lin   | ie.                                  | was                         | 1025                         |                  |                         |                          |                         |  |                             | Interval Between<br>Onset and Death     |
| 1                   | Medical   |                              | disease or condition resulting in death)   | n                                 | a. Due to (or as  | V 1                                  |                             | 0 0                          | E                | mon                     | 1774                     |                         |  |                             | YEARS                                   |
|                     | Examiner  | ē                            | Sequentially list co   | enditions,                        | b. Due to (or as  | 2 CONSEQUE                           | ince off:                   |                              |                  |                         |                          |                         |  | +                           |   |
|                     | ted<br>ansi   | Examine                      | if any, leading to in<br>cause. Enter Unde<br>Cause (Disease or                  | rlying<br>injury                  | Due to (or as   | a conseque                           | ince oi).                   |                              |                  |                         |                          |                         |  | - 1                         |   |
|                     | be executed<br>sician and<br>burial-transi  | al Ex                        | that initiated event<br>resulting in death)                                      |                                   | Due to (or as   | a conseque                           | nce of):                    |                              |                  |                         |                          |                         |  |                             |   |
| 09/                 | ate be<br>physici<br>the bu   | edice                        |  |                                   | d   |                                      |                             |                              |                  |                         |                          |                         |  |                             |   |
| . Box 68760         | Attending Physicien: The law requires that the death certificate be exe streath.  strobath.  by the funeral director, page 2 should be detached for use as the burial-  | Completed by Physician/Medic | IF FEMALE:<br>23b. Was decedent<br>in the past 12:<br>1 ☐ Yes 2 €<br>9 ☐ Unknown | months?                           | 23c. If yes, outcome<br>1  Live Birth<br>4  Pregnant<br>9  Unknown          | 2  Fetal at time of de               | death 3                     | Ectopic preg<br>Other (speci |                  | ,                       |                          |                         | 23d. Date<br>Mor   | e of delive                 | ry<br>Day <b>Ye</b> ar                  |
| P.O.                | that the  | y Pt                         | Part II. Other signif  | ficant conditions of              | contributing to death   | but not resul                        | lting in the u              | ınderlying cau               | se give          | en in Part I.           | 23e                      | . Did toba              | cco use contri   | bute to the                 | e cause of death?                       |
| S,                  | requires the been signer should be  | ed b                         | ATP  | IAL                               | -1BR10  | LA                                   | TTOV                        | $\nu_{-}$                    |                  |                         | - 1                      | 1 🗆 Yes                 | s 2 □ No   | 3 🗌 Prob                    | ably 4 Unknown                          |
| Š                   | aw rec<br>as bee<br>2 sho   | plet                         | 147  | PERT                              | ONS101  | V                                    |                             |                              |                  |                         | 24a                      | . Was an                |  | ere autop                   | sy findings available                   |
| Re                  | The law<br>ate has<br>page 2  | ပ္ပြ                         | CHE  | PONIC                             | OBSTA   | PUCTI                                | We F                        | PULM                         | in               | ARY NS                  | SARBE                    | _ perform               | ed2 d  | eath?                       |   |
| ta                  | i <b>cien:</b> The<br>certificate<br>rector, pag  | Be B                         | 25. Was case referrence examiner?  |                                   | Hospital:   |                                      |                             | 2                            | 6. Plac<br>Other | ce of Death (C          | Check only on            | <del>)</del>            |  |                             | :1===================================== |
| Į V                 | Phys<br>rthis<br>eraldii  | 6                            | 1 ☐ Yes 2 2<br>27. Manner of Deat  |                                   | 1 Inpa  |                                      | R/Outpatier<br>28b. Time of | nt 3 DOA                     | Injury           | 4 L Nursin              |                          |                         | ce 6 Othe  |                             | HOSTICE                                 |
| n o                 | ath.<br>: After<br>e funer  | cate                         | 1 ✓ Natural<br>2 ☐ Accident  | 5 Pending Investigatio            | (Month, Da  |                                      | injury                      |                              | work?            | res 2 □ No              | 1                        | CHDC HOW                | rijury occurre   | u                           |   |
| .≥                  | Il or Attenciate after death  | Certificate:                 | 3  Suicide<br>4  Homicide  | 6 Could not be determined         | 28e. Place of In  | jury - At hom<br>tc. (Specify)       | ne, farm, str               | eet, factory, of             | fice             |                         |                          | ation (Stre<br>or Town, | et and Numbe<br>State)   | r or Rural i                | Route Number,                           |
| 1                   | To the Hospital or within 24 hours afte to the Funeral Dir. completely filled in  | Medical (                    |  | Medical Exam                      | rsician: To the best on<br>niner: On the basis of<br>rse Practitioner: To t | examination :                        | and/or inves                | tigation, in my              | opinior          | n, death occur          | red at the time.         | date and                | place, and due   | to the cau                  | se(s) and manner stated.                |
| y                   | To the To the Comple  | Σ                            | 29b. Signature and   |                                   | se Practitioner: 10 t   | A Dest of the                        | / Knowledge                 |                              |                  | number                  | id place, and c          |                         | d. Date signed   |                             |   |
|                     | Um  |                              | > m  | uns                               | 4/-   | th                                   | o K                         |                              | 74               | 636                     | 0                        | 1                       | VAY  | 4                           | 2012                                    |
|                     | . 9.  |                              | 30. Name and addr  | ess of person who                 | completed cause of  | death (Item 2                        | 23a) (Type, F               | Print) L                     | 70               | 1 Non                   | 27/4/                    | hap                     | IDS G  | 00-                         | Burn                                    |
|                     | Sta   | te                           | 31. Date filed (Mont   | 7/100 J                           | 32. Regist  | r's Sign tu                          |                             | 1:30                         | , -              | 100                     | INC                      | 11100                   |  | COT                         | INVI PARCES                             |

| 12-03446  |  | Ple  |                                       |                     |                               | Black In                      |                         |                  |                             |           |                         |                    |                         | gible             | ) <b>.</b>                  |              |                                     |
|---|--|--|---------------------------------------|---------------------|-------------------------------|-------------------------------|-------------------------|------------------|-----------------------------|-----------|-------------------------|--------------------|-------------------------|-------------------|-----------------------------|--------------|-------------------------------------|
| Daniel Kenneth  | _  | dzinski<br>I- For State  | St                                    | tate of             | Maryla                        | nd / Depa                     |                         |                  |                             | nd M      | 1ental                  | I Hygi             | ene                     |                   | 20                          | 112          | 1465                                |
|   |  | Registrar  | · · · · · · · · · · · · · · · · · · · | U = 1 = = 40        |                               | Cel                           | rtificate               | OT D             | eatn                        |           |                         | To r               | Pate of Dea             | eg. No.           |                             |              |                                     |
| Physicia<br>Medical Examin  | ner  | 1. Decedent's Nam  | 1                                     | Danie               |                               |                               | Jagoo                   |                  |                             |           |                         | N                  | Month<br>lay 4, 20      | Day<br>12         | Year                        | 06           | ne of Death<br>615 hrs              |
|   |  | 4a. Facility Name (  |                                       |                     |                               |                               |                         |                  | City, Town,<br>hoenix       | or Loca   | ition of D              | Death              |                         |                   | County of Daltimore C       |              |                                     |
| Funeral   |  | 5. Social Security N   |                                       | 6. Sex              |                               | 7. Age (In yrs. I             | ast birthda             | y) If            | Under 1 Y                   | ear If    | Under 2                 | 4Hrs. 8.           | Date of Bi              | rth(MM/I          | DD/YYYY) 9.                 |              | (State or                           |
| Director  |  | 214-17-1   |                                       | 1 X M               | 2 F                           | 26                            |                         | Yrs.             | Months Da                   | ays I     | Hours                   | Min.               | oct.                    | 16,1              | 6,1985 Foreign Country) MD  |              |                                     |
| kus.  | ŀ  | Usual Residence o<br>10a. State  | f Decedent<br>10b. County             |                     |                               | 10c. City,                    | Town or L               | ocation          |                             |           |                         |                    |                         |                   |                             | 10d. I       | Inside City Limits                  |
| <b>.</b> .  | _  | MD   |                                       | Balti               | imore                         |                               |                         |                  | Dι                          | ında      | ı1k                     |                    |                         |                   |                             | 1 [          | Yes 2 X No                          |
| th the Maryland<br>23a or 28a-f show<br>notified at once.   | Director   | 10e. Street and Nu   | mber                                  |                     |                               |                               |                         | 10               | f. Zip Code                 | )         |                         |                    | 1                       | 10g. Citiz        | g. Citizen of What Country? |              |                                     |
| 3a or   |  | 8052 De  | el Hav                                | en Ro               | oad                           |                               |                         |                  | 21222                       |           |                         |                    |                         | Un                | ited S                      | States       | 3                                   |
| th with   | Funeral  | 11. Marital Status 1 Never Married 2 Married Armed Forces?   |                                       |                     |                               |                               |                         |                  | ecedent of I<br>specify Cub |           |                         |                    |                         | D-                | 14. Race - Al<br>White, et  |              | dian, Black,                        |
| er dea  |  | 3 Widowed 4 Divorced If Yes, Glve Yaar   |                                       |                     |                               |                               |                         | ı∏ Ye            | s 2 X                       | No soe    | ecify:                  |                    |                         |                   | Specify: White              |              |                                     |
| urs aft<br>tural'   | ğ  | 15. Decedent's E   |                                       | L OI                | Dates:                        | e completed)                  |                         | edent's L        | Isual Occup                 | pation (  | Give kind               |                    | done                    |                   | (ind of Busine              | ess/Industry |                                     |
| 72 ho   | Completed  | Elementary/Seco  | ondary (0-12)                         |                     | College (1-                   | 4 or 5+)                      | duri                    | ng most o        | of working li               | ife. DO   | NOT use                 | e retired)         |                         |                   |                             |              |                                     |
| Medis   | 티  | 11 Year  | rs                                    |                     |                               |                               | La                      | abore            | er                          |           |                         |                    |                         |                   | onstru                      | ıctior       | n                                   |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica  |  | 17. Father's Name  |                                       |                     | 12                            |                               |                         |                  |                             |           |                         | name (Fir<br>a Mil | st, Middle,             | Maiden            | surname)                    |              |                                     |
| 212<br>uld be<br>Menta<br>mark  | To Be  | Josej<br>19a. Informant's Na   | oh Jago<br>me/Relations               | Odz11<br>ship (Type | 1SK1<br>e, Print )            |                               |                         |                  |                             | reet and  | Number                  | r or Rura          | Route Nu                |                   | ty or Town, S               |              |                                     |
| MD<br>d 2 sho<br>ith and<br>a 27 is   | Natalie M. Genco (Companion) 8052 Del Haven Road Dundalk, Maryl  |  |                                       |                     |                               |                               |                         |                  |                             |           |                         | Maryla             | nd 21                   | 222               |                             |              |                                     |
| re, I and I and Healt Fitem   | Ī  | 20a. Method of Dis   |                                       |                     | Pamoval fra                   |                               | Place of D<br>crematory |                  | (Name of o                  | cemeter   | ry,                     | Da                 | ate                     | 20c. L            | ocation - Cit               | y or Town,   | State                               |
| Pages<br>nent ol  |  | 4 Donation 5   | _                                     |                     |                               | Hi                            |                         |                  | vice                        |           |                         |                    | 2012                    |                   | owson,                      |              |                                     |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath, and Mental Hygiene. Important: If item 27 is marked other than "antural", or items 23a or 28a-1 sho injury or other traumatic event, the Medical Examiner must be notified at once  | Ì  | 21. Signature of Fu  |                                       |                     | Scot                          | t P. Ga                       | rdne                    | 22. Name<br>Duda | and Addre                   | ess of F  | <sup>acility</sup> nera | 1 Ho               | me of                   | Dui               | ndalk,                      | Inc.         | 0.0                                 |
|   | _  | 23a. Part I. Enter th  | ne disease o                          | r complica          |                               | used the death                | Do not er               | 792              | 2 Wis                       | e Av      | ve.                     | Dun<br>liac or res | dalk,                   | Man<br>rest. sho  | yland                       | 212<br>  App | 22<br>proximate Interval            |
| Physician<br>/Medical   |  | failure. List or   | nly one cause                         | on each             | line.                         |                               | . 50 1151 61            |                  |                             | .,        |                         |                    | F                       | , , , , , , , , , |                             |              | ween Onset and<br>Death             |
| £xaminer  |  | Immediate Cause or condition resulti   |                                       |                     | ultiple Inju<br>e to (or as a | consequence o                 | of):                    |                  |                             |           | ·                       |                    |                         |                   |                             | +            |                                     |
|   |  | Sequentially list co   | onditions,                            | b                   |                               |                               |                         |                  |                             |           |                         |                    |                         |                   |                             |              |                                     |
|   | iner   | if any, leading to in<br>cause. Enter Under  | erlying Cause                         |                     | e to (or as a                 | consequence o                 | of):                    |                  |                             |           |                         |                    |                         |                   |                             |              |                                     |
|   | Examiner   | (Disease or injury to events resulting in  |                                       |                     | e to (or as a                 | consequence o                 | of):                    |                  |                             |           |                         |                    |                         |                   |                             |              |                                     |
| cecuted<br>and<br>- transit   | ल  |  |                                       | d                   | MENDED                        |                               |                         |                  |                             |           |                         |                    |                         |                   |                             |              |                                     |
| O,<br>e be e;<br>ysiciar<br>burial  | ğ  | UNPENDED   | <u> </u>                              |                     | AMENDED                       |                               |                         |                  |                             |           |                         |                    |                         | 1220              | d. Date of del              | ivon         |                                     |
| Box 68760, e death certificate be ex the attending physician cd for use as the burial   |  | IF FEMALE:<br>23b. Was decedent<br>past 12 months  |                                       |                     | 1 Live bi                     | utcome of preg<br>rth         | nancy<br>2 [            | Fetal            | leath 3                     | зЕ        | ctopic pr               | regnancy           |                         |                   | Month                       | Day          | Year                                |
| Box 6 e death cer the attendi   | sicia  | 1 Yes 2  |                                       |                     | -                             | ant at time of de             | eath 5                  | Other            | (Specify)                   |           |                         |                    |                         |                   |                             |              |                                     |
| b. BC<br>the de   | Phy  | Part II. Other sign  |                                       |                     |                               | death but not r               | esulting in             | the unde         | rlying caus                 | e given   | in Part I               | l. 1               | 23e. Did 1              | tobacco           | use contribut               | e to the cau | use of death?                       |
| cords, P.O. law requires that the has been signed by 2 should be detach   | á  |  |                                       |                     |                               |                               |                         |                  |                             |           |                         |                    | 1 Ye                    | s 2 🗸             | No 3                        | Probably     | 4 Unknown                           |
| rds,<br>requir<br>been s  | Completed  |  |                                       |                     |                               |                               |                         |                  |                             |           |                         |                    | 24a. Was                |                   |                             |              | findings available tion of cause of |
| 9CO<br>ne law<br>te has<br>ge 2 sl  | Ē  |  |                                       |                     |                               | -                             |                         |                  |                             |           |                         | _                  |                         | ormed?            | deat                        |              | 2 No                                |
| I R   |  | 25. Was case refe  | rred to medica                        | al                  |                               |                               |                         |                  | 26.Pla                      | ace of D  | eath (Ch                | heck only          |                         |                   |                             | ]            |                                     |
| Vital Rechysician: The this certificate   | To Be  | examiner?<br>1 <b>✓</b> Yes  | 2 No                                  | Hos                 | pital: 1 Ir                   | patient 2                     | ER/Outp                 | atient 3         | DOA                         | Othe      | <sup>er</sup> ₄         | lursing H          |                         |                   | nce 6 🗸 C                   | Other: Scen  | е                                   |
| Division of Vital Records, and or Attending Physician: The law require at the dear detail. The law require and records that dear this certificate has been sitted in by the funeral director, page 2 should the funeral director. | • • •  | 27. Manner of Dea  |                                       |                     | 28a, Date of (Month, Unknown  | of Injury<br>Day, Year)       | 28b. Tim<br>Unknov      | e of Injur       |                             | njury at  | _                       |                    | d. Describe<br>ver auto |                   | iry occurred<br>collision   |              |                                     |
| SiO! Attended the control of the  | The standard of the standard o |  |                                       |                     |                               |                               |                         |                  |                             |           | ute Number City         |                    |                         |                   |                             |              |                                     |
| Divi  | 复  | Suicide 6 Could not be determined (Specify) Major Road / Highway  Suicide 6 Could not be determined (Specify) Major Road / Highway  Suicide 6 Could not be determined (Specify) Major Road / Highway |                                       |                     |                               |                               |                         |                  |                             |           |                         |                    |                         |                   |                             |              |                                     |
| Hospit<br>24 hour<br>Funera   |  | 29a. Certifier 1   | Certifying F                          | Physician           | : To the best                 | of my knowled                 | lge, death              | occurred         | at the time,                | , date ai | nd place                | , and due          | to the cau              | ise(s) an         | d manner as                 | stated.      |                                     |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be extoned to the Natural Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial  | edical   | one) 2   | Medical Ex                            | aminer:0            | n the basis o                 | f examination a               | and/or inve             | stigation,       | in my opin                  | ion, dea  | ath occur               | rred at the        | e time, date            | end pla           | ice, and due                | to the caus  | e(s)                                |
|   | Me   | 29b. Signature and   |                                       | ier                 |                               |                               |                         |                  | 29c. Lice                   |           |                         |                    |                         |                   | Date signed                 | (Month, Da   | ay, Year)                           |
| 6 gm  |  | hi   | , an                                  |                     |                               |                               |                         |                  | 0.0                         | C.M.E     |                         |                    |                         | May               | 4, 2012                     |              |                                     |
| Mic   |  | 30. Name and add   | •                                     |                     | •                             | e of death (Iten<br>niner 900 |                         | imore '          | Street P                    | altimo    | оге Мг                  | 2122               | 3                       |                   |                             |              | 7                                   |
|   |  | Ling Li, MD  |                                       |                     |                               |                               |                         | innoie (         | J. 1861, D                  | amilio    | JIE, IVIL               | 2 1 1 2 2 .        |                         |                   |                             |              |                                     |
| 5   | tate   |  | X 2012                                | 12.                 | 444                           | gist ar's Signat              | The same                |                  |                             |           |                         |                    |                         |                   |                             |              |                                     |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| ouglas Franklin  |                | es State<br>- For State  | e of Maryland / Depar<br>Certi   | tment of He<br><i>ificate of De</i> |   | l Hygiene<br>Reg          | 201  | 2 1466                     |
|--|----------------|--|--|-------------------------------------|---|---------------------------|--|----------------------------|
| Physician  |                | egistrar<br>. Decedent's Name (First, Middle,La                    |  | . 1                                 |   | 2. Date of Death          | Day Year                                       | 3. Time of Death           |
| Modical Examin   | er             | Dougle   | as trankly   | <u>200 a</u>                        | es  | May 3, 2012               | 2 4c. County of Death                          | 2014 hrs                   |
|  | 4              | la. Facility Name (if not institution), g<br>University Hospital   | ive street and number)   |                                     | y, Town, or Location of D<br>timore                 | reatti                    | Polto (  | Pitu                       |
| Funeral  | 5              |  | Sex 7. Age (In yrs. las  |                                     | nder 1 Year If Under 2                              |                           | (MM/DD/YYYY) 9. Birt                           | hplace (State or           |
| Director   | 1              | 013-108-5220 1   | XM 20F 56  | Yrs. Mo                             | nths Days Hours                                     | Min. Jan 1:               |  | untry) MD                  |
| <b>b</b>   |                | Jsual Residence of Decedent  10a, State 10b, County                | Inc City T   | own or Location                     |   |                           | 1  | 10d. Inside City Limits    |
| iow any  |                | NA Lan   | 20=1 81  | Linall                              | City  |                           |  | 1 ☐ Yes 2 ☑ No             |
| arylanc  | Director       | 10e. Street and Number   | ula I CI   | 10f.                                | Zip Code  | 100                       | g. Citizen of What Cour                        | ntry?                      |
| the Manner or 2  |                | 8637 Smi   | th ave   |                                     | 21043   |                           | UJA  |                            |
| e death with the Maryland<br>or items 23a or 28a-f sh<br>must be notified at once  | Funeral        | 11. Marital Status  1 Never Married 2 Marri                        | 12. Was Decedent Ever in U.S<br>Armed Forces?  |                                     | edent of Hispanic Origin<br>ecify Cuban, Mexican, P |                           | 14. Race - Ameri<br>White, etc.                | can Indian, Black,         |
| er deat  |                |  | 1 Yes 2 No   | 1 Yes                               | 2 No specify:                                       |                           | Specify: P)                                    | ack                        |
| nurs aft<br>stural"  | 핡              | 15. Decedent's Education (Specify                                  | or Dates:  |                                     | ual Occupation (Give kin<br>working life, DO NOT us |                           | 16b. Kind of Business/                         | ndustry                    |
| 6<br>1.72 ho   |                | Elementary/Secondary (0-12)  | College (1-4 or 5+)  |                                     | 00 - 04 =   |                           | 1000   | 20100                      |
| 5-0036 led within 7 Hygiene. I other than the Medica   | Completed      | 17. Father's Name (First, Middle, La                               | st)  | LILLY                               | 8.Mother's  | Name (First, Middle, M    | aiden Surname)                                 | APIUG -                    |
| 7 =  | Be             | Ollie  | Jones Sr.  |                                     | 12  | lla The                   | mas  |                            |
| 2121<br>hould be f<br>nd Mental<br>is marked<br>atic event,  | ᄋ              | 19a. Informant's Name/Relationship                                 | (Type, Print)  | 19b. Mailing Add                    | ess (Street and Number                              | er or Rural Route Numb    | per, City or Town, State                       | , Zip Code)                |
| ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati  |                | MC LOCATE JD 20a. Method of Disposition                            |  | lace of Disposition (               |   | Date                      | 20c. Location Oty or                           | Town, State                |
| Baltimore,<br>permit. Pages I an<br>pepartment of He<br>Important: If ite  | П              |  | 3 Removal from State   | rematory or other pl                | ace)  | 5/8/10                    | Month  | mia Man                    |
| Baltimo<br>permit. Page.<br>Department o<br>Important:<br>injury or oth  | J              | 4 Donation 5 Other Special Signature of Funeral Service Lit        |  | 22. Name                            | and Address of Facility                             | Slackh                    | ureral Hi                                      | mo PiA.                    |
|  | 1              | Weldertole   | July + Mola  | 793 387                             | 1 Old Colu  | mbic Pil                  | HONOIS PAR                                     | App a mate Interval        |
| Physician<br>/Medical  |                | 23a. P Enter the disease, or co<br>failure. List only one cause on | each line.   |                                     | ge or gying, such as can                            | glac of respiratory arre- | st, snoon, or noun                             | Between Onset and<br>Death |
| Examiner   | 1              | Immediate Cause (Final disease or condition resulting in death)    | a. Contact Gunshot Wound  Due to (or as a consequence of)  |                                     |   |                           |  |                            |
|  |                | Sequentially list conditions,                                      | b  |                                     |   |                           |  |                            |
|  | jue            | if any, leading to immediate cause. Enter Underlying Cause         | Due to (or as a consequence of c.  | ):                                  |   |                           |  |                            |
| od<br>sit  | Examine        | (Disease or injury that initiated events resulting in death) Last  | Due to (or as a consequence of   | ):                                  |   |                           |  |                            |
| and - tra  | edical         | UNPENDED   | d  |                                     |   |                           |  |                            |
| cords, P.O. Box 68760, law requires that the death certificate be exhaps been signed by the attending physician 2 should be detached for use as the bunal  |                | IF FEMALE:   | 23c. If yes, outcome of pregn  | nancy                               |   |                           | 23d. Date of deliver                           |                            |
| 6876(<br>certificate<br>nding physe as the b   | ian/           | 23b. Was decedent pregnant in the<br>past 12 months?               | 1 Live birth 4 Pregnant at time of dea   | 2 Fetal de<br>ath 5 Other (         |   | oregnancy                 | Month  | Day Year                   |
| Box 6876<br>e death certificate<br>the attending phy<br>ed for use as the b  | Physician/M    | 1 Yes 2 No 9 Unkno   | 9 Unknown  |                                     |   |                           |  |                            |
| D. hat the ed by t   | D P            | Part II. Other significant condition                               | ns contributing to death but not re  | esulting in the under               | lying cause given in Part                           |                           | 2 No 3 Pro                                     | bably 4 Unknown            |
| JG, P<br>quires t  | E E            |  |  |                                     |   | 24a. Was a                | n   24b. Were a                                | utopsy findings available  |
| Cord<br>law rec<br>has be  | Completed      |  |  |                                     |   | autops<br>perform         | med? death?                                    | completion of cause of     |
| Rec: The liftcate I  |                | 25. Was case referred to medical                                   |  |                                     | 26.Place of Death (C                                | 1 Yes 2                   | 2 No 1 Y                                       | es 2 No                    |
| of Vital Recing Physician: The After this certificate funeral director, page   | o Be           | examiner?  1 Ves 2 No  | Hospital: 1 Inpatient 2  | ER/Outpatient 3                     | DOA Other4  | Nursing Home 5            | Residence 6 Othe                               | эг:                        |
| of onergine of the other than one other th | n: To          | 27. Manner of Death  | 28a. Date of Injury<br>FOUND:  | 28b. Time of Injury FOUND:          | 28c. Injury at Work?                                | Subject shot              | ow injury occurred self                        |                            |
| Sion<br>Attendideath.<br>Sctor:  | catio          | 1 Natural 5 Pendir 2 Accident Investi                              | 9 1401 2 2012  | 1730 hrs                            | 1 Yes 2   |                           | treet and Number or R                          | ural Route Number, City    |
| Divisior pital or Attencours after death   | Certification: | 3 ✓ Suicide 6 Could 4 Homicide                                     | not be   | Jine, Iaim, 30000, Ia               | story, office balleting, oto.                       | or Town, St               |  |                            |
| Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach  |                | 29a. Certifier 1 Certifying Phy                                    | sician: To the best of my knowledge  | ge, death occurred a                | at the time, date and place                         | e, and due to the caus    | e(s) and manner as sta                         | ited.                      |
| To the Hos within 24 h To the Fun completely   | Medical        | one) 2 Medical Exam  | iner: On the basis of examination a<br>and manner stated.  | nd/or investigation,                | in my opinion, death occ                            | urred at the time, date a | and place, and due to t<br>29d. Date signed (M |                            |
|  | Σ              | 29b. Signature and title of certifier                              | )  |                                     | O.C.M.E.  |                           | May 4, 2012                                    | o, boy, rour,              |
| 100  |                | 30 Name and address of nerson w                                    | /ho completed cause of death (Item   | 1 23a)                              |   |                           |  |                            |
| Ō  |                | Ling Li, MD Assistan   | t Medical Examiner 900   | W. Baltimore S                      | treet, Baltimore, M                                 | ID 21223                  |  |                            |
|  |                | 31. Date filed (Month, Day, Year)                                  | 32. Registrar's Signatu  | ire Was                             |   |                           |  |                            |
| Regis  | uer            | MAIUUCUIC  | A STATE OF THE STA |                                     |   |                           |  |                            |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Helen Jean Jensen Day May 2012 06, 1:30 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford County 2199 Cantley Court Forest Hill 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year)

Jan. 29, 1925 Days Months Hours Min. 212-22-9299 87 Director 1 M 2 AF Baltimore, MD. Usual Residence of Decede 10a. State or than "natural", or items 23a or 28a-f sho the Medical Evaniner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Harford County Forest Hill 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2199 Cantley Court 21050 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ρ filed within 72 hours after Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Ň/A Home Maker Own Home Be permit. Page 1 and 2 should be file.
Department of Health and Mental Humportant: If item 27 is merimportant: If item 27 is merimportant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Albert A. Laur Margaret G. Simpson 19a. Informant's Name/Relationship (Type, Print) Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr.Holger Bernhardt Jensen 2199 Cantley Court Forest Hill.Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Wednesday Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) May 09,2012 Baltimore, Maryland Signature of Funeral Service Licensee Jeffrey L.Cair, Sr. 07902. Name and Address of Facility Leader Line Property Land Cremation Center, P.A. Lic. #00677 2325 York Road Timonium, Maryland 21093-2215 (at 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. Listorily one cause on each line. Approximate Interval Between Immediate Cause (Final Al heiners Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami use as the burial-transit The lew requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy ō in the past 12 months? Day 5 Other (specify) ate has been signed by the a page 2 should be detached t g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 Ø No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of Artifier blas MD 29d. Date signed (Month, Day, Year) 29c. License number

10

31. Date filed (Month, Day, Year) State MAY 0 9 2012 Registrar

SYED Q. ABBAS

6701 N Charles Street Sul 4105 Baltimore MD 21204 37. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D72139

Physician/ Medical **Examiner Funeral Director** or 28a-f show notified at 10a. State Director MD ms 23a or Funeral items the Medical Examiner ŏ þ Baltimore, Maryland 21215-0036 "natural", Completed al Hygiene. I other than " Be and Mental F is marked o ٩ KIAH, JOAN Department of Health and Meni Important: If item 27 is marke any injury or other traumatic Ph\_sician/ Medical **Examiner** Examine nding physician and use as the burial-transit Physician/Medical P.O. Box 68760 IF FEMALE: the a signed by the þ Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 14662 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Zol2 Month 1 09:49 M Kiah 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore City Sinai Huspital of Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min (Month, Day, Year) 240-88-8294 1 □ M 2 🗓 F North Carolina 58 Jul. 12, 1953 Usual Residence of Decede 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2858 Rosalind Avenue 21215 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clothing Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shirlene Johnson Joe Doggett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 Minnie Hopkins (Sister) 3403 W. Rogers Avenue, Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date L. Harold Poole Funeral Service 1 Burial 2 X Cremation 3 Removal from State 5/5/2012 4 Donation 5 Other (Specify) Knightdale, NC ature of Fyneral Service L 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine Street, Alexandria, VA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDS disease or condition resulting in death) Due to (or as a consequence of) day. septic snock Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ATRIAL FIBRILLATION & ASCITES Hospital or Attending Physician: The law requires 124 hours after death.
Funeral Director: After this certificate has been sign 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy tor: After this certificate has the funeral director, page 2 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 \sum Yes 2 \sum No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5  $\square$  Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) RES-000 April 24,2012. MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aileen Pan, MD Sinai Huspital Baltimore 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

MAY 09

amend 7,9,10a,16b,per fh,g927 5-9-12 sm.
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend items 7,8 per fh g927 5-15-12 vt.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 394 4a. Facility Name (if not institution, give street and number) M 05 Medical 2017 Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltings If Under N/A niversing Manjand Medical Cunus **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth Months Days Hours Min. (Month, Day, 594-01-7103 Director 1977 1 **X** M 2 □ F Florida Usual Residence of Decedent 10,28 "natural", or items 23a or 28a-f show idical Examiner must be notified at 10b. Count 10a. State MC 10c. City, Town or Location Baltimore the Maryland 10d. Inside City Limits Director N/A 1 Yes 2 □ No MD 10f. Zip Code 21 229 10e. Street and Number 508 Yale Avenue 10g. Citizen of What Country? Funeral with permit. Page 1 and 2 should be filed within 72 hours after death N Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, Black by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Specif 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) University of MD MD McClear Center Elementary/Secondary (0-12) College (1-4 or 5+) Staff Specialist 12th 2vrs Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) မှ Trolis Kirby Helen Fountain 19a. Informant's Name/Relationship (Type, Print)
Shavona Kirby/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 Yale Ave. Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery 5/10/12 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn, MD Denation 5 Other (Specify) 22. Name and Address of Facility Beverly D. Cromartie F/S 2700 Edmondson Ave. Balto., MD 21223 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) rununia Medical Due to (or as a consequence of): Examiner 21/2 weeks Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the hours. P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, HIV 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 178 097 5730 16 05,03, 2012 Show of and address of person who completed cause of death (Item 23a) (Type, Print) Michelle 22 South Greene St Balnucke KIM , MD 2120 31. Date filed (Month, Day, Year) State

Registrar

MAY 0 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ MAY 201<sup>Year</sup> 06. 7:35 AM KEMAKH MIKHAIL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST CENTER HOWARD COUNTY COLUMBIA HOWARD If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Davs Hours Director 217-39-9621 1 🛛 M 2 🗆 F POLAND 06/12/1924 87 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County must be notified at Director 1 Yes 2x No HOWARD COLUMBIA MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral items 23a 21045 USA 7080 CRADLEROCK WAY, APT. 919 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 9 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 Divorced 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) TURNER MACHINERY 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F ပ္ KEMAKH UNKNOWN PEYSA other traumatic ABRAHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 7080 CRADLEROCK WAY, APT. 919, COLUMBIA, MD 21045 KHANA PETERBURGSKAYA/WIFE 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, injury or JUDEAN MEMORIAL GDNS: 05/07/2012 OLNEY, MD Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS.. any i 8900 REISTERSTOWN ROAD, PIKESVILLE, 21208 23a. Part 1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Due to (or as a Immediate Cause (Final Physician/ COLLINIASCOPION disease or condition Medical resulting in death) (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Grant Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 X To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No 2 Accident Investigation Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only or

State Registrar and title of certifier

09

2012

29b. Signature

Cedar

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

29c. License number

29d Date signed (Month, Day, Year)

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 29 Pay Physician/ APRIL 2012 5:45 P M LARISA KANAYEVA Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE BALTIMORE COURTLAND GARDENS 8. Date of Birth (Month, Day, Year, 10/25/192 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Months Hours 1 □ M 2X F 220-37-6643 86 RUSSIA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 10a. State within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director BALTIMORE BALTIMORE 1 ☐ Yes 2X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 7920 SCOTTS LEVEL ROAD 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 No Specify. If Yes, Give Specify. 3X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) it. Page 1 and 2 should be filed withindment of Health and Mental Hygiene reant: If item 27 is marked other the njury or other traumatic event, the MEDICINE 5+ PEDIATRICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 UNKNOWN UNKNOWN UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) YOLANDA DORSEY / GUARDIAN 611 CENTRAL AVENUE, SUITE 301 TOWSON, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place)
ANSHE EMUNAH ATTZ
CHATM CEMETERY 20c. Location - City or Town, State 20a. Method of Disposition Department of Important If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 05/01/2012 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funenal Service Ocen.e. 22. Name and Address of Facility SOL LEVINSON & BROS., ichica 8900 REISTERSTOWN ROAD PIKESVILLE, 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ADVANCED ALZHEIMER'S DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by ATHEROSCLEROSTIC CARDIOVASCULAR DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy funeral director, page 2 performed 1 Yes 2X No After this certificate 1 ☐ Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at X Natural work? 5 Pending 1 Tes 2 No Accident Suicide Investigation after death filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 24 hours a Funeral I Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

completed

within 2 To the I

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

HOWARD B.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COHEN, M.D.,

DHMH 17 Rev 7/2009

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

6717 PARK HEIGHTS AVENUE, BALTIMORE, MD

29d. Date sign

d (Month, Day, Year)

21215

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1 Decement's Name (First Middle, Last) **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and hu Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) March 19,1947 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. Maryland 1 X M 2 □ F 65 Director 212-46-5018 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Dunda1k MD <u>Baltimore</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code United States 21222 1 Eastship Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify. Specify: þ White 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore County al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Government Office Manager 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aldona A. Velivlis Leonard J. Layman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 Eastship Road Dundalk, Maryland permit. Pages 1 and 2:
Department of Health as Important: If item 27 Is any Injury or other trauonce, Mrs. Victoria F. Layman (Wife) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Stanislaus Cemetery5/5/2012 4 🗌 Donation 5 Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dundalk Marvland 21222 Funeral Service License 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disc ase, or complications that caused the death. shock, or heart fally e. List only one cause in each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Find **Physician** disease or condition resulting in death) 3/Medical e to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that is libeted expenses) Examiner The law requires that the death certificate be executed attending physician and d for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy Live birth 2 Fetal death ate has been signed by the atten page 2 should be detached for y in the past 12 months? Month Day 5 Other (specify) 4 Pregnant at time of death 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No No 1 Yes this certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death Check on one Be examiner? Other: 4 Nursing Home 1 Ves 2 No Hospital: 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Inpatient ၉ Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the funeral Certification: After Injury Natural 2 Accident 5 Pending investigation 1 Tyes 2 🗌 No Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, in by determined City or Town, State) 4 Homicide within 24 hours a To the Funeral D To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

11595

State

10

and address of person

4940 Eastern Avenue, Baltimore, MD, 21224

ho completed cause of death (Item 23a) (Type, Print)

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14667 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death WWIN CLARA Physician/ Month MAY 2012 10:30AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11 SLADE AVENUE, #309 PIKESVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** RUSSIA 1 □ M 2 🗓 F Months Days Hours Min. 07/17/1921 90 Yrs. 213-16-5869 Director Usual Residence of Decedent ems 23a or 28a-f show r must be notified at 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No PIKESVILLE MD BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral and 2 should be filed within 72 hours after death with 11 SLADE AVENUE, #309 21208 iral", or items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 X Widowed 4 Divorced th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ADMINISTRATOR SINAI HOSPITAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JOSEPH SUSSERMAN CECILIA SILVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 MARK LEVIN / SON 5802 DALE ROAD, BALTIMORE, MD 21209 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If ite any injury or ot 1  $\boxtimes$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State HAR SINAI CONG. 05/08/2012 OWINGS MILLS, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Sérvice Litter of 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Onset and Death END STACE KIDNEY Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** PEANES HYPENTEN SWN Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No ρ 1 ☐ Yes 2 € g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FAT/VM? CONGSTIVE HEART Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed HTPERLIPINEMIA Were autopsy findings available prior to completion of cause of 24a. Was an death? PEMPHENAL VASULAR DISEASE 1 ☐ Yes 2 🗷 N 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending s after death. 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral I

completed filled Medical 29a. Certifier 1 🖔 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 00047625 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 OCLER DINF, suite 311. TOW SON IMD PICHARD O'MALLEY, MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAY 2012 LEVIN 02:35AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST HOSPICE CARE TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Min. (Month, Day, Year) Hours 212-48-0744 **Director** 1 X M 2 □ F 65 04/25/1947 PA Usual Residence of Deced 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ Funeral Director notified 1 Yes 2 X No MD BALTIMORE BALTIMORE ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be 23a 1820 AUTUMN FROST LANE 21209 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ral", or iten Examiner Black, White, etc. þ 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. Specify. "natural", Completed 3 Widowed 4 Divorced WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SENIOR CLAIMS ADJUDICATOR STATE OF MARYLAND alth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ LEVIN BENJAMIN SARAH DOBRES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 NORMA LEVIN / WIFE 1820 AUTUMN FROST LANE, BALTIMORE, MD 21209 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Ę, BOBROISKER BENEFICIAL 05/06/2012 1 X Burial 2 Cremation 3 Removal from State = 5 Department of Important: If any injury or once. ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) ervice Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part . Enter the disease, or complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physicians/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine deduction is continued at cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Month g 🗌 Unknown Part II. Other significant conditions equiributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 page 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No Investigation Accident Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examin er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated e Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse only one

State Registrar 29b. Signature a

31. Date filed (Month, Day,

NAY 09

of cextifier

DHMH 17 Rev 06-2011

Name and address of person who completed cause of death (Item 23a) (Type, Print)
WWY Shaheeu, 6701 N. Charles St. \$4105, Balthure, MO 21204

29c. License number

D0071287

29d. Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Dacedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day OT: OY PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** If Under 24 Hrs 219-32-5900 74 Director 1 🔀 M 2 🗆 F 07/09/1937 Delaware 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 28a-f **Baltimore** 1 Tes 2 No Md Lutherville ò 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21093 USA 903 Chestnut Ridge Drive "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Divorced 4 Divorced Year or Dates. traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Attorney Law and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Lee Mix Katherine Lucille Reinhart 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is rany injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia P. Mix(Wife) 903 Chestnut Ridge Drive Lutherville, Md. 21093. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) County Cremation 05/06/2012 Sykesville, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Box 195 Sykesville,Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami the burial-trans Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 Live Gath signed by the atter d be detached for in the past 12 months? 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown completely filled in by the funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death? To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 X No Hospital Other: မ 1 Yes 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu completed cause of death (Item 23a) (Type, Print) dress of person who MANTINAM State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Joseph Mason 0900M 30 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Randallstown Baltimore Genesis Randallstown 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Nov 30. 1925 86 **Director** 214-20-1209 Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits

1 ☐ Yes 2 ☐ No within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location Director **Baltimore Baltimore City** MD 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral U.S.A. 21217 727 Druid Park Lake Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iter Armed Forces? 1X Yes 2 No11/13/195 Black, White, etc. o. þ 1 X Never Married 2 Married timore, Maryland 21215-0036 **Black** 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify Completed 3 Widowed 4 Divorced 11/12/195 permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Railroad **Employee** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bessie Morris Harold Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1614 Westwood Avenue, Baltimore, MD 21217 1614 Westwood Avenue, Harold Mason 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State May 10, 2012 Owings Mills, Md. **Garrison Forest Veterans** 4 Donation 5 Other (Specify) Signature of Fund al Service Lice Name and Address of Facility
 Estep Brothers Funeral Service, P. A.
 1300 Eutaw Place Baltimore, Md 21217
 Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Holvanced Dementia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and tran that initiated events Due to (or as a consequence of): resulting in death) Last the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death the g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔏 Unknown Carcinoma Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy page 1 ☐ Yes 2 🕱 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospita Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After work?
1 Yes 2 No 1 X Natural 5 Pending injury Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D71493 04/30/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randalls tow MD 21133 9/09 Liberty Rd.

State

Registrar

31. Date filed (Monti

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 5:30P Robert Cecil McKibbin May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 207 Purlington Rd. Baltimore Timonium 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 8, 1925 If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Hours 1 XX M 2 □ F 192-16-4011 Minnesota 86 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director Maryland Baltimore Timonium 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 207 Purlington Rd. United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 X Yes 2 ☐ No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: I Hygiene. other than "natural", If Yes Give Year or Dates. WW II Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) business owner motel supply Be permit. Page 1 and 2 should be filed Department of Hoalth and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Robert B. McKibbin Corinne Tallman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie McKibbin/wife 207 Purlington Rd. Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Oulaney Valley Mem GardMay 10,2012 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Jöhhn Chi Mircher V IV, Funeral Services of Dulaney 200 E. <u>Padonia Rd. Timonium, MD 21093 Valley, P</u> Mitch 200 E. Padonia Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CONCI UNG disease or condition resulting in death) 119/5 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): and -transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? perform Hospital or Attending Physician: The ☐ Yes 2 XNo 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No n 24 hours after death.

The Funeral Director: A pleted filled in by the f death. Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier mpleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the l within 2 To the l only one) 29b. Signature and title of certif 29d, Date signed (Month, Dav. Year) 7,2012 and address of person who completed cause of death (Item 23a) (Type, Print) /W) 734 York Varuel

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAY 0 9 2012

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 2012 THOMAS WILLIAM McGINN, SR. 4:50 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Maples of Towson Baltimore County Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 🛛 M 2 🗆 F Months Hours (Month, Day ept 14 Maryland **Director** 213-09-5012 99 Usual Residence of Decedent items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Lutherville Maryland | Baltimore County 1 🗆 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 108 Strathdon Way 21093 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Patrick McGinn Jodie Marian Cole permit. Page 1 and 2 should Department of Health and M. Important: If item 27 is man any injury or other traumati once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 762 Alexander Drive, Belhaven, NC 27810 Mrs. Janet Bull (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Dul. Valley Mem Grdns:5/8/2012 Timonium, Maryland 21. Signat All Land Seylo (Censor) 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC.
6500 York Road, Baltimore, Maryland Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Pheumonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi ause (Disease of linjury the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 4 Pregnant Pregnant at time of death 5 Other (specify) Month Dav Year 1 ☐ Yes 2 ☒ No 9 ☐ Unknown been signed by the sahould be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Failure to thrive 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 2 No 1 🗌 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ALF 1 🗌 Yes 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ogn 35 5-4-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Michelle Abramowski

31. Date filed (Month, Day, Year)

MAY 0 9 2012

Charles

10TOI N.

St. # 4105 Baltimore, MD 21204

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Pamela McCardell   | 1- For State<br>Registrar   | tate of Maryla  |                          | rtment of<br><i>tificate of</i> |  | d Mental I      |  | Reg. No. 20  | 12 1467  |  |  |
|--|---|---|--------------------------|---------------------------------|--|-----------------|--|--|--|--|--|
| Physician/<br>Medical Examiner   | Decedent's Name (First, Midd  | <sub>lle,Last)</sub><br>Pamela                                    | Mc(                      | Cardell                         |  |                 | 2. Date of Dea<br>Month<br>April 30, 2 | Day Year   | 3. Time of Death<br>0001 hrs                       |  |  |
|  | 4a. Facility Name (if not institution Good Samaritan Hos  |   | nber)                    |                                 | 4b. City, Town, or<br>Baltimore              | Location of Dea | ath                                    | 4c. County of D  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number 212-90-5563   | 6. Sex  | 7. Age (In yrs. la<br>45 | ast birthday)<br>Yrs            | Months Days                                  |                 | lin.                                   | 2,1966   | Birthplace (State or oreign Country) MD            |  |  |
| w any  | Usual Residence of Decedent  10a. State  10b. County  |   | 10c. City,               | Town or Locat                   | ion  |                 |  |  | 10d. Inside City Limits                            |  |  |
| the Maryland a or 28a-f show any tified at once. Director  | MD B  | altimore  |                          |                                 | Parkv:                                       | ille            |  | 10g. Citizen of What 0                                 | 1 Yes 2 No   |  |  |
| with the l<br>ns 23a or<br>be notifie  | 2304 Ellen  | 12. Was Dece  | edent Ever in U.         |                                 | s Decedent of His                            |                 | Specify Yes or No                      |  | merican Indian, Black,                             |  |  |
| s after death<br>iral", or iten<br>inter must le<br>by Fune  | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Ar White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Race - Ar White, etc. 17. Was Decedent Ever in U.S. 18. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Widowed 4 Divorced of Yes, Give Year On Dates: 19. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Specify: 19. Specify:   |   |                          |                                 |  |                 |  |  |  |  |  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director | MD Baltimore Parkville    10e. Street and Number   10g. Citizen of What Contains the park to the park |   |                          |                                 |  |                 |  |  |  |  |  |
| MD 21215-0036 at 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the <u>Medica</u> To Be Complé   | 12 Years 1 Year Homemaker Own Home 7 Father's Name (First, Middle, Last)  William E. Shifflett 9a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State   |   |                          |                                 |  |                 |  |  |  |  |  |
| MD 21 d 2 should lth and Mer n 27 is man To  | Mr. Phillip K.  | ,   | Jr.                      | 2304                            | Ellen A                                      | venue           | Parkvil                                | 1e, MD 2   | 1234   |  |  |
| Baltimore, permit. Pages I an Department of Hea Important. Wite Important: Wite Important: Wite Impury or other transparent  | 20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other S  | pecify:   | m State C<br>Hi]         | rematory or oth                 | ition (Name of cen<br>her place)<br>ervice C |                 | Date 5/2012                            | 20c. Location - City                                   | or Town, State<br>Maryland                         |  |  |
|  | 21. Signature of Funeral Service  | /   |                          | טע ו                            | ame and Address<br>da-Ruck<br>22 Wise        | Funeral         | Home of undalk,                        | f Dundalk,<br>Maryland                                 | 21222  |  |  |
| Physician<br>/Medital<br>Examiner  | failure. List only page cause  Immediate Cause (Final disease or condition resulting in death)  | on each line.   | done ar                  | d Alpr                          |  |                 |  | est, shock, or flear                                   | Approximate Interval<br>Between Onset and<br>Death |  |  |
| - E  | Sequentially list conditions, if any, leading to immediate  | b<br>Due to (or as a  |                          |                                 |  |                 |  |  |  |  |  |
| 0, s be executed sician and burial - transit edical Examiner   | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | c.<br>Due to (or as a   | consequence of           | ):                              |  |                 |  | ····   |  |  |  |
| e be executed sician and burial - transit  | X UNPENDED  | 7/4   |                          |                                 | er me,g92                                    | 7 5–10-         | -12 sm                                 |  |  |  |  |
| ox 6876 eath certificate attending phy for use as the  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 ✓ Uni   | 1 Live bir  | nt at time of dea        | 2 Fet                           | al death 3 [<br>ner (Specify)                | Ectopic preg    | nancy                                  | 23d. Date of delive Month                              | very<br>Day Year                                   |  |  |
| P.O. B es that the digned by the detached if   | Part II. Other significant condit   | tions contributing to   | death but not re         | sulting in the u                | nderlying cause g                            | ven in Part I.  | 23e. Did to                            |  | to the cause of death?                             |  |  |
| of Vital Records, P.O. ag Physician: The law requires that if wher this certificate has been signed by meral director, page 2 should be detacted. To Be Completed by F.  |   |   |                          |                                 |  |                 | 24a. Was<br>autop<br>perfo<br>1 ✓ Yes  | osy prior death  |  |  |  |
| Vital Rehysician: The this certificate I director, page  | 25. Was case referred to medical examiner?  1 ✓ Yes 2 No  | transfer  | patient 2                | ER/Outpatient                   |  | of Death (Chec  |  | Residence 6 Ot   | her:   |  |  |
| ion of \ tending Ph, eath. tor: After ti the funeral ation: Ta   | 27. Manner of Death  1 Natural 5 Pend   | ding  | Day,Year)                | 28b. Time of Ir                 |  | at Work?        | I -                                    | how injury occurred took pres                          | scription  |  |  |
| Division o<br>spital or Attending<br>tours after death.<br>neral Director: After<br>filled in by the fune<br>Certification:  | 3 X Suicide 6 Couldete  | 28e. Place  |                          | me, farm, stree                 | t, factory, office bu                        | uilding, etc.   | 28f. Location (S                       |  | Rural Route Number, City<br>en Ave.                |  |  |
| Divis  To the Hospital or At within 24 hours after of the Funeral Direct completely filled in by Medical Certific.   | one) 2 Medical Exa  | hysician: To the best<br>miner: On the basis of<br>and manner sta | examination an           |                                 |  |                 |  |  |  |  |  |
| P Z  | 29b. Signature and title of certified   | Halla   | i                        |                                 | 29c. License<br>O.C.N                        |                 |  | 29d. Date signed (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii | Month, Day, Year)                                  |  |  |
| $\phi$   | 30. Name and address of person Carol Allan, MD As   | who completed cause<br>sistant Medical E                          | •                        |                                 | imore Street,                                | Baltimore, N    | MD 21223                               | <b>.</b>   |  |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)  NAY 0 9 2012   |   | istrar's Signatur        | als                             |  |                 |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  |                           | State of Maryland / Department of Health and Per dr., g927,03/09/2012dhb Certificate of Death  | Mental Hy                                    | giene<br>Beg. No. 201                         | 2 11671  |
|--|---------------------------|--|--|---|--|
| Physicia   |                           | 1. Decedent's Name (First, Middle, Last)  Edinard C. Miller Tr.  | 2. Date of De Month                          | Ballet W.                                     | 3. Time of Death Unknown   |
| Medic<br>Examin  |                           | 4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Deat  3635 Lockwood Road Baltimore  |  | 4c. County of Dea                             | more   |
| Funeral<br>Director  |                           | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  Usual Residence of Decedent  6. Sex 7. Age (In yrs. last birthday)  If Under 1 Year If Under 24 Hrs  Months Days Hours Min.   |  | y, Year) C                                    | irthplace (State or Foreign ountry)  |
| ne Mary/and<br>or 28a-f show<br>notified at  | rector                    | 10a. State 10b. County 10c. City, Town or Location  Baltimore Baltimore  |  |   | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No                                       |
| ath with the I   | Funeral Director          | 3625 Loc Kwood Road 10f. Zip Code 21207  |  | 10g. Citizen of What C                        | Country?   |
| 036<br>s after dea<br>ral", or ite   | by                        | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No Specify: Year or Dates.   | pecify Yes or No-<br>to Rican, etc.)         | 14. Race - Am<br>Black, Wh<br>Specify:        |  |
| red C Mill erre. Maryland 21215-0036 1 and 2 should be filed within 72 hours after free that had Mental Hygiene. 1 tem 27 is marked other than "natural", of the traumatic event, the Medical Examother traumatic event, the Medical Examother traumatic event.  | Completed                 | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of wo.)  iffe. DO NOT use retired)   | rking  | 16b. Kind of Business                         | s/Industry   |
| laryland 212 should be filed within and Mental Hygiene, a marked other than aumatic event, the name of the part of | To Be C                   | FILE OF MALLEY   | me (First, Middle,                           | Maiden Surname)                               | ore Jun  |
| T =  | 1000                      | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Nymber or Ru  19b. Mailing Address (Street and Nymber or Ru  19b. Mailing Address (Street and Nymber or Ru  19c. Miller III/Son 14/1 Saddle + 100   | /  | er, City or Town, State, 2                    | Zip Code)<br>MD 21787  |
| Imo<br>Imo<br>Page<br>nent o<br>ant: If  |                           | 20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5  Other (Specify)  20b. Place of Disposition (Name of cernetery, crematory or other place)  | Date - 2012                                  | 20c. Location - City of Baltimo               | ore, mo  |
| Balti<br>permit.<br>Depart<br>Importa<br>any inji  |                           | Vausha C. Brune 8728 Liberty Road  | /  | Greene Fi                                     | 11) & 1133   |
| Phylian Medical  |                           | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiant shock, or hear failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  | c or respiratory ar                          | rest,   | Approximate<br>Interval Between<br>nset a y D <sub>3</sub> , th              |
| executed an and trial-transit  | dical Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of): | ose.   |   | 20 years   |
| Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. The fourth Director: After this certificate has been signed by the attending physicistely filled in by the funeral director, page 2 should be detached for use as the but  | Completed by Physician/Me | IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy  1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)  9 ☐ Unknown   |  | 23d. Date of d<br>Month                       | delivery<br>Day Year   |
| ords, P.O. Borrequires that the despensioned by the should be detached   | ed by Ph                  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | cobacco use contribute Yes 2 No 3             | to the cause of death?  Probably 4  Unknown                                  |
| Recorc   | Somplet                   |  | 24a. Was<br>auto<br>perfi<br>1 \(\sum \) Yes | psy prior to<br>ormed? death?                 | autopsy findings available o completion of cause of ? //es 2 \( \sum_{NO} \) |
| f Vital Rec<br>Physician: The la<br>this certificate ha  | To Be                     |  | eck only one) Home 5 Resi                    | dence 6 Other (Spe                            | ecify)   |
| Division of Vital Records, re Hospital or Attending Physician: The law requires no 24 hours after death. The tribic certificate has been signietely filled in by the funeral director, page 2 should be  | Certificate:              | 27. Manner of Death  1  Natural  | 28f. Location (                              | Street and Number or F                        | Rural Route Number,  |
| Div<br>Hospital or<br>4 hours afte<br>Funeral Dir  | Medical Co                | 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred  | , and due to the c                           | and place, and due to the                     | e cause(s) and manner stated.  |
| To the Hosp<br>within 24 ho<br>To the Fune<br>completely f   | Me                        | only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and 29b. Signature and title of certifier  29c. License number  | place, and due to                            | the cause(s) and manner 29d. Date signed (Mor | as stated.   |
| (10)   |                           | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   | uary L                                       | de H.   | 21209-   |
| Stat<br>Registra   |                           | 31. Date filed (Month, Day, Year)  32. Registrar's Signature   |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Year If Under If Unde 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 24 Hrs. **Funeral** Hours Director 1 🕅 M 2 🗆 F 64 Yrs 232-76-4119 1947 Virginia 2, June West Usual Residence of Deced permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location Director 1 X Yes 2 □ No Shepherdstown WV Jefferson 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25443 USA 10 Dorset Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Narried þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. If Yes, Give Specify: White Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) State Farm Insurance Agent Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Willie Midkiff Mary Midkiff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Wife) 10 Dorset Way, Sheperdstown, WV Midkiff 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 🛱 Burial 2 🗌 ¢remation 3 🔲 Removal from State Ridgelawn Mem Park 5-10-2012 Huntingtown, WV ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility etropolitan Funeral Service 517 Vine St., Alexandria, VA ignature of Fun ral Service Licens Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) neumonia Medical Due to (or as a consequence of) **Examiner** Multiple Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending <sub>I</sub> IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Day Pregnant at time of death Other (specify) been signed by the s should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed' death? 1 ☐ Yes 2 ☐ No Yes 2 🔽 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5  $\square$  Pending 4 hours after death.

\*uneral Director: Aftely filled in by the fulled in the fulled i Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, in 24 hous. the Funeral Directory filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24

To the F

complet 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 1 Registrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 7. Physician/ A M Russell Leroy Mason 1:23 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Marlboro Prince George's 9316 Croom Road Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 225-12-2355 Director 1 X M 2 D F 89 Oct. 17, 1922 Virginia Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits death with the Maryland Director Maryland Prince George's 1 X Yes 2 No Upper Marlboro 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be n Funeral 9316 Croom Road 20772 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. once. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Musician Band Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ed Mason Blanche Susan Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chana Phyllis Sackel (Wife) 9316 Croom Rd., Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Byrial 2 Cremation 3 Remo wal from State Mt. Hebron Cemetery 5-10-12 Winchester, VA 4 Donation Other (Specify) Signature of Fu eral Service Lic 22 Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, VA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line ediate Cause (Final age or condition Interval Between Onset and Death Immediate Cause (Final Phylician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Chaering Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ for in the past 12 months? Month Year Pregnant at time of death 2 No detached Unknown a 🗌 I Inknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death? Yes 2 X No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DCA မ 4 Nursing Home 5 X Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral o 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state only one

State Registrar 29b. Signatu

MELIDA 31. Date filed (Month, Day, Year)

and title of certifier

Vunanda

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WELDA R. MANDA 74. (150.

R. MIRANDA

OSPORNE SE LOG

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2012 14677 State of Maryland / Department of Health and Mental Hygiene Reginald D McNeil 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 3, 2012 2342 hrs Medical Examiner Keginald D. McNei 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Baltimore** Union Memorial Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 215-72-0124 45 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a, State MD 1 Yes 2 No BATTIMORE permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10g. Citizen of What Country? USA 2910 Edison 21213 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No 1 Yes Specify: BLACK 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 3 Widowed ੬ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CONSTRUCTION ltimore, MD 21215-0036 Laborer 17, Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) HARRIS MCNEIL AMES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRIS 910 Edison MOTHER 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition PARKWOOD CEMETERY 1 Burial 2 Cremation 3 Removal from State BATTIMORE, MD 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licens Part I. Enter the disease, or complication failure. List only one cause on each line Approximate Interval Physician Between Onset and Medical Death Immediate Ceuse (Final disease a Complications of Gunshot Wounds and Blunt Force Injuries ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and hysician/Medical AMENDED23a,pt.II,27,28a-f,per me,g932 10-9-12 sm X UNPENDED icate has been signed by the attending physician page 2 should be detached for use as the burial To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bunit Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death 1 Live birth 3 Ectopic pregnancy Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ā Division of Vital Records, P.O. ģ 1 Yes 2 No 3 Probably 4 Unknown Cirrhosis of the liver Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? Yes 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Other Nursing Home 5 Residence 6 Other Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🔝 2 No 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification 1 Natural victim of multiple assaults 1 Yes 2 X No 5 Pending 1993 and 1999 unknown 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be or Town, State) determined 4 X Homicide unknown unknown 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and file of certifier 29d. Date signed (Month, Day, Year) 29c. License number May 4, 2012 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Donna M. Vincenti, MD State

DHMH 17 Rev 1/2001 **OCMF 2006** 

Registra

OCME

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

| 2 ( | ) | 2 | 1 | L | 6 | 7 | 8 |
|-----|---|---|---|---|---|---|---|
|-----|---|---|---|---|---|---|---|

| TIVIII O. WOIGAII, DI  | 1- For State Registrar   | Certificate o                              |   |                                      | g. No.                                    |   |
|--|--|--|---|--------------------------------------|---|---|
| Physician/<br>Medical Examine  | Decedent's Name (First, Middle,Last)   |  | *   | 2. Date of Death<br>Month            | Dav Year                                  | 3. Time of Death 2210 hrs                   |
| ***  | Alvin $S$ . 4a. Facility Name (if not institution, give street and nu                                      |  | organ Sr.  4b. City, Town, or Location of                       | May 6, 201<br>f Death                | 4c. County of Death                       | 22101113                                    |
|  | 5302 Elsrode Avenue  |  | Baltimore   |                                      |   |   |
| Funeral<br>Director  |  | 7. Age (In yrs. last birthday)             | Months Days Hours   | Min                                  | h(MM/DD/YYYY) 9. Birth<br>Foreign         |   |
|  | 218-96-2474   1X M 2 F   Usual Residence of Decedent   | 38 Yr                                      | S.  | 04 28                                | 3 73 Cou                                  | ntry) MD                                    |
| v any  | 10a. State 10b. County   | 10c. City, Town or Loca                    | ation   | - <u>-</u>                           | I   | 10d. Inside City Limits                     |
| fland fland once.  | MD NA  | Balti                                      |   |                                      |   | 1 X Yes 2 No                                |
| the Maryland a or 28a-f show tified at once. Director  | 10e. Street and Number   |  | 10f. Zip Code 21214   | 10                                   | g. Citizen of What Count                  | ry?   |
|  | 5302 Elsrode Ave 11. Marital Status 12. Was Deca   | edent Ever in U.S. 13. W                   | as Decedent of Hispanic Orig                                    | in? ( Specify Yes or No-             | U.S.A.                                    | an Indian, Black,                           |
| er death with to, or items 23s. Franks be not  | 1 Never Married 2 Married Armed Fo   | rces? If                                   | Yes, specify Cuban, Mexican,                                    | Puerto Rican, etc.)                  | White, etc.                               |   |
| s after ral", o  | 3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grad      |  | Yes 2 X No specify:   |                                      | Specify: Bla                              |   |
| 5-0036 ed within 72 hour Mygiene. other than "natu the Medical Exau Completed  | Elementary/Secondary (0-12) College (1-  | during r                                   | nt's Usual Occupation (Give k<br>nost of working life. DO NOT ( |                                      | 16b. Kind of Business/In                  | dustry                                      |
| 21215-0036 Juld be filed within 7 Mental Hygiene. marked other than marked other than cevent, the Medica                             | llth grade na  | Sheet                                      | Metal Work  | er                                   | Man Power                                 | Services                                    |
| 15-C<br>filed v<br>I Hygi<br>ed othe<br>t, the C   | 17. Father's Name (First, Middle, Last)  |  |   | s Name (First, Middle, M             | •   |   |
| 2121<br>tould be fil<br>to d Mental I<br>is marked<br>tic event,   | Alvin S. Morgan Sr.  19a. Informant's Name/Relationship (Type, Print)                                      | 19b. Mailir                                | g Address (Street and Num                                       | y Chapman<br>ber or Rural Route Numb | L<br>per, City or Town, State, :          | Zip Code)                                   |
| MD dd 2 shoulth and lith and m 27 is numatic   | Betty Chapman-Mother   |  | Renshaw Av  | e, Baltim                            | ore, Md 2                                 | 1215  |
| ore, es lan of Hea. If iten  | 20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from  |  | sition (Name of cemetery,<br>ther place)                        | Date                                 | 20c. Location - City or T                 |   |
| Baltimore,<br>pernit. Pages I ar<br>Department of Hee<br>Important: If ite   | 4 Donation 5 Other Specify:  | On-Si                                      |   |                                      | 2 Baltimor                                | e, Md                                       |
| Bal<br>permi<br>Depar<br>Impo  | 21. Signature o Peral Servi pe   | Ma   | Name and Address of Eacility<br>Arch F/H Wes<br>300 Wabash A    | t<br>Wo Balti                        | mara Ma                                   | 21215                                       |
| Physician  | 23a. Part I. Seer the disease, or complications that ca fail. List only one cause on each line.            | used the death. Do not enter               | the mode of dying, such as ca                                   | rdiac or respiratory arres           | st, shock, or heart                       | Approximate Interval Between Onset and      |
| /Medical<br>Examiner   | Immediate Cause (Final disease a. Heroin   | Intoxication                               |   |                                      |   | Death                                       |
|  | ,  | consequence of):                           |   |                                      |   |   |
| ner  | Sequentially list conditions,  | consequence of):                           |   |                                      |   |   |
| red nisit Examiner   | (Disease or injury that initiated C.   | consequence of):                           |   |                                      |   | -   |
| xecuted  | d.   | 23a,pt.II,27,2                             | 9a F nor ma a   | 077 5-72-17                          | Cm  |   |
| ox 68760,<br>ant certificate be execu-<br>attending physician and<br>or use as the burial - tra<br>sician/Medical                    |  |  | oa-i,pei me,g   | 927 J-23-12                          |   |   |
| 3876<br>rtificat<br>ing phy<br>as the  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, o                               | utcome of pregnancy<br>rth 2 Fe            | etal death 3 Ectopic  | pregnancy                            | 23d. Date of delivery  Month Da           | y Year                                      |
| ). Box 687 : the death certific. by the attending p sched for use as th Physician/I  | 1 Yes 2 No 9 Unknown 9 Unknown   |  | ther (Specify)  |                                      |   |   |
| 9 - 9  | Part II. Other significant conditions contributing to  |  | underlying cause given in Par                                   | t I. 23e. Did tob                    | acco use contribute to th                 | e cause of death?                           |
| s, P.O. ires that the signed by I be detach  | Cocaine and ethanol use  | 2  |   | 1 Yes                                | 2 No 3 Proba                              | bly 4 🗹 Unknown                             |
| ords, w requires to should bletee  |  |  |   | 24a. Was ar<br>autopsy               | y prior to co                             | psy findings available mpletion of cause of |
| Records, I The law requires ficate has been signate, page 2 should be Completed  |  |  |   | perform<br>1 ✓ Yes 2                 |   | 2 No  |
| of Vital Records, ng Physician: The law require ther this certificate has been si neral director, page 2 should b n: To Be Completed | 25. Was case referred to medical examiner?   | patient 2 ER/Outpatien                     | 26 Place of Death (0  |                                      |   |   |
| n of Viding Physion.  After this funeral direction: To   | 27. Manner of Death 28a. Date of   | of Injury 28b. Time of                     |   |                                      | esidence 6 🗹 Other: 5                     | scene                                       |
| Division o spiral or Attending nours after death or and Director: After filled in by the fune Certification:                         | 1 Natural 5 Pending Accident Pending Investigation   | Day, Year) -6-12 fd 10:                    | 00 pm 1 Yes 2 🗓   | No unknown                           |   |   |
| Division safer death. al Director: A led in by the fi  | 3 Suicide 6 X Could not be 28e. Place  | of Injury - At home, farm, stre            |   | or Town Sta                          | reet and Number or Rura<br>ate)5302 EISTC | Route Number, City                          |
| Divis  | 29a. Certifier   | found at ho                                |   | Baltimor                             |   |   |
| To the Hos<br>within 24 h<br>To the Fur<br>completely  | one) 2 Medical Examiner: On the basis of   | examination and/or investiga               |   |                                      |   |   |
| A SES  | 29b. Signature and title of certifier  | 3.64                                       | 29c. License number   |                                      | 29d. Date signed (Monti                   | n, Day, Year)                               |
|  | Pate Un - PSC  | let -                                      | O.C.M.E.  |                                      | May 7, 2012                               |   |
| Ø  | <ol> <li>Name and address of person who completed cause<br/>Patricia Aronica-Pollak MD. Assista</li> </ol> | of death (Item 23a)<br>nt Medical Examiner | 900 W. Baltimore Stre   | et. Baltimore MD                     | 21223                                     |   |
| State  |  | shar's Signature                           |   | ,                                    |   |   |
| Registrar  | NAY 0 9 2012 A   | una J. p.                                  | ented   |                                      |   |   |
| DHMH 17 Rev 1/2001<br>OCME 2006  | OCME   | ORIGINA                                    | L   |                                      |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1707 PM OMINIC ames 05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Country) 98 Director 061-03-5507 1 M 2 XX Usual Residence of De Jan 15, 1914 Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10c. City. Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes XX No MD Frederick Frederick 10e, Street and Number 10f. Zip Code 9 10g. Citizen of What Country? ms 23a or must be r Funeral 3533 Hopeland Rd. 21704 ral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2XX No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tyes 2 XXNo Specify: "natural", Specify: 3 ₩Widowed 4 □ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.

27 is marked other than
er traumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Draftsman Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rocco Miraldi Angiolina Galiano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marianne Elliott 2533 Hopeland Rd., Frederick, MD 21704 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of I Important: If it any injury or o 1 XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) French Hill Cemetery May 15, 2012 Cameron, NY ire of Funeral Service Name and Address of Facility
Fink Funeral Home, P.A. Gregory M01148 426 Crain Hwy S., Glen Burnie, MD 21061 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. See only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Hypoxia Medical resulting in death) Examiner Respiratory Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) attending physician for use as the buris Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1  $\square$  Yes 2  $\square$  No 3  $\square$  Probably 4  $\square$  Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of this certificate has ral director, page 2 autopsy performe death' 2 🗌 No 1 \sum Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death Certificate: 1 Natural 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of 28d. Describe how injury occurred after death. Director; After (Month, Day, Year) 5  $\square$  Pending Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OV SGREENEST BOLLIMORE MD 21701 ordan

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month. Day, Year)

azus

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Month 2340 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** of Death tospita andover If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Months (Month, Day, Year) **Director** YORK or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 √es 2 □ No Shington 10e. Street and Number 10f. Zie Code 10g. Citizen of What Country? Funeral items 23a 100 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 D No 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates. 3 Widowed 4 Divorced and Mental Hygiene. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) DREVENTION Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ဂ acon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is CD 12401 Weldon Wanar LIV. bruthe 20772 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place Riverdale, MD -15-2012 22. Name and Address of Facility WISeman 7527 ad Hexandria 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? To the Hospital or Attending Physician: The law requires that the death Month Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 🗌 Yes after death.

Director: After this certification by the funeral director, 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital 1 Yes ဂ 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending injury work? Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) filled in Medical 1 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $M_{ay}^{Month}6$ ,  $20^{Day}$ Physician/ Katherine E. McKenna 6:20 A MMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5025 White Flint Drive Montgomery Kensington If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe . Age (In yrs. last birthday) **Funeral** 96 Months Hours June 20, 577-48-6283 1915 Pennsylvania **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5025 White Flint Drive 20895 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George E. Casterline Ottilie Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan C. Boswell/Daughter 5025 White Flint Drive, Kensington, Maryland 20895 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Parklawn
Memorial Park May 12 2012 1 X Burial 2 Cremation 3 Removal from State Rockville, Maryland 4 Donation 5 Other (Specify) Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death 10 days Physician/ Pneumonia Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Be Completed ျ

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after deat Funeral Director:

and the burial-trai

attending physician I for use as the buria

signed by the a

should peen

page 2

filled in by the

Certificate:

Medical

29b. Signature and title of certifier

After this certificate

show

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

| 1 Yes 2 🖾 No<br>9 🗌 Unknown                           | 4 Pregnant at time of death 9 Unknown   | 5 ☐ Other (specif                   | 'y)   |   | Worth Day real  |  |  |  |  |
|---|---|-------------------------------------|---|---|---|--|--|--|--|
| Part II. Other significant conditions  Cardiomyopathy | contributing to death but not resulting   | in the underlying caus              | se given in Part I.   |   | se contribute to the cause of death?  No 3 Probably 4 Unknown                               |  |  |  |  |
| Hypertension  |   |                                     |   | 24a. Was an autopsy performed? 1  Yes 2  No | 24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No |  |  |  |  |
| 25. Was case referred to medical                      |   | 26. Place of Death (Check only one) |   |   |   |  |  |  |  |
| examiner?<br>1  Yes 2  No                             | Hospital: 1  Inpatient 2  ER/O  | utpatient 3 DOA                     | lome 5 🖺 Residence 6 🗆 Other (Specify)  |   |   |  |  |  |  |
| 27. Manner of Death  1                                | (Month, Day, Year)  | injury                              | Injury at<br>work?<br>1 □ Yes 2 □ No  | 28d. Describe how injury                    | occurred  |  |  |  |  |
|   | 28e Place of Injury - At home for   | arm, street, factory, of            | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |   |   |  |  |  |  |
| (Check 2 Medical Exa                                  | ysician: To the best of my knowledge,<br>miner: On the basis of examination and/<br>irse Practioner: To the best of my know | or investigation, in my             | opinion, death occurred   | at the time, date and place,                | and due to the cause(s) and manner stated.  |  |  |  |  |

29c. License number

D58645

29d. Date signed (Month, Day, Year)

May 7, 2012

within 24 ho
To the Fune
completed fi

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrea Karp, M.D. 10215 Fernwood Road, #100, Bethesda, Maryland 20817

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature Barks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 3:00 A Paul George Morin, Jr. Mav Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore 2126 Rosalie Avenue If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month. Day, Year) Months Hours 218-68-7516 56 **Director** 1**X**M 2 □ F Yrs. January 8, 1956 Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits at rector 1 U Yes 24 No notified Baltimore Baltimore Maryland Ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Examiner must be 23a Funeral United States of America 21221 2126 Rosalie Avenue items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces? 1 ☐ Yes 2XX No ō 1 X Never Married 2 ☐ Married ģ Maryland 21215-0036 1 Yes 2 XXNo Specify If Yes, Give Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) State of Maryland Maintenance 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jean C. Donald Paul George Morin, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3032 Arizona Avenue, Parkville, MD 21234 Sheila Beall - Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Evans Funeral Chapel and Cremation Services Belair Forest Hill, Maryland 4 Donation 5 Other (Specify) May 9, 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chaptel and Cremation Services - Parkville 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Months Sequentially list conditions, Examine Due to jor as a consequence of: cause. Enter Underlying sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed bin 80 hours after a new requires that the death certificate be executed to 80 hours after a new requirement. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9 Unknown P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I ᅌ 1. Yes 2 No 3 Probably Division of Vital Records, Unknown Completed 24b. Were autopsy findings available 24a. Was an cate has page 2 s autopsy performed? Yes 2 X No prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical funeral director 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2X No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 1 Natural Accident 5  $\square$  Pending work?
1 Yes 2 No ithin 24 hours after death.

the Funeral Director: Aft
ompletely filled in by the ful Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifie License number 29d. Date signed (Month. Day, Year) to completed cause of death (Item 23a) (Type, Print) north, Day, Year) 0 9 2012 32. Registrar's Signature State Registrar

Registrar

2012 14684

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #State of Maryland / Department of Health and Mental Hygiene Megan McCormack Certificate of Death 1- For State Reg. No. 3. Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day May 1, 2012 Vear Physician/ 2318 hrs al Examiner Megan Renee McCormack

4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Anne Arundel Glen Burnie Baltimore Washington Medical Center If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Hours Months Davs Maryland 09/25/1992 Director 2 X F Yrs 19 1 M 215 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Yes 2 No or items 23a or 28a-f show must be notified at once. Odenton Anne Arundel MD with the Maryland 10g, Citizen of Whet Country? Director 10f. Zip Code 10e, Street and Number 2453 Warm Spring Court 14. Race - Americen Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married r death 2 X No 1 Yes Specify: White 1 Yes 2 No specify: If Yes. Give Year 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", of injury or other traumatic event, the Medical Examiner. 16b. Kind of Business/Industry 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036  ${\sf School}$ Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) Renee Irene Behling Be Duane Thomas McCormack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ပ <u>Maryland</u> 2453 Warm Spring Ct. Odenton. Renee I. Behling / Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5/10/12 Crownsville, Maryland <u>Crownsville VA Ceme</u> 4 Donation 5 Other Specify 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licen or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part I. Inter the disease Between Onset and Physician failure. List only one wuse on each line. Death (Medical Seizure Disorder Immediate Cause (Final disease ∠xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or es a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit ca AMENDED 23a, 27, per me, g928 6-21-12 sm e attending physician a for use as the burial X UNPENDED Physician/Medi The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant in the 1 Live birth past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown for n signed by the a 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown 2 Completed 24b. Were autopsy findings available 24a. Was an ficate has been s , page 2 should l prior to completion of cause of autopsy certificate has l 1 🗸 Yes 2 No Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after teath.

To the Funeral Director: After this certificompletely filled in b. the funeral director, Be Other, Nursing Home 5 Residence 6 Other: Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 1 Yes 2 No 1 X Natural 5 Pending Division 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 6 Could not be 3 Suicide (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 3, 2012 O.C.M.E. MO 9 Wishall 30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year) State Registra

Pamela E. Southall, MD

32. Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death May 4, Day 2012 **Physician** Vincent McCLain 0955 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Northwest Hospital Randallstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/08/1959 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ F Months Days Hours MD 217-74-3025 52 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Exa⊞lner must be notified at ¹¥Yes 2□No Director Lyconia Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 956 Memorial Avenue 17701 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specif Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates 'natural", the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Dishwasher Food Service other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event once. Be Velma Evoria McClain William Pratt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6050 Moravia Pk Dr #206 Baltimore, MD 21206 Velma McClain-Green/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 8, 2012 Baltimore, MD On-Site Crematory Funeral Servi ignature John L. Williams Funeral Directors, P.A. 4517 Park Hgts Ave Baltimore, MD 21215 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shopk, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arteriosclerotic Cardio-Vascular Disease disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 9 Unknown 9 Unknown signed by t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed page certificate 1□ Yes 2₽No director, 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No 2 ER/Outpatient 3 □ DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 24 hours after death Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D007552

May 4, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Magth 7, 201/2 Physician/ Mary Bernardine Murphy 9:15 AM Medical 4a. Facility Name (if not institution, give street and number)
Stella Maris Hospice 4b. City, Town, or Location of Death Halethorpe 4c. County of Death
Baltimore **Examiner** 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. ocial Security Number 215–30–6906 8. Date of Birth **Funeral** 1 🗆 M 2 🖁 F Months Days Hours Marchay2007 1920 **Director** Yrs show 10a, State MD notified at City Town or Location Halethorpe 10d. Inside City Limits Baltimore Director 28a-f 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? d Mental Hygiene. marked other than "natural", or items 23a or matic event, the Medical Examiner must be r Funeral 1800 Palo Circle 21227 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black. White, etc. þ 1 Never Married 2 Married 21215-0036 within 72 hours after 1 Yes 2 XNo Specify: White If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Registered Nurse Health Lane Be Maryland should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Francis Mullaney Marie Glorius and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2323 Mountain Rd. N. W. #7 Albuquerque, NM 87104 item 27 Michael E. Murphy, Jr. Page 1 and 2: other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State Meadowridge Memorial Park 05-12-2012 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Faneral Service Licensee Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mo of dying, such as cardiac or respiratory arrest, Approximate Interval Between Inset and Death shock, or heart failure. List only one cause an each line Immediate Cause (Final Physician disease or condition resulting in death) UMWIO Medical Due to (or a v. consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician dbe detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed need 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an After this certificate has director, page 2 • Hospital or Attending Physician: The 24 hours after death. • Funeral Director: After this certificate h MURPHY 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral! 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a d title of certif Date signed (Month, Day, Year) ρ M 2012 lac 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 ERNESTINE WRIGHT, M.D. 31. Date filed (Month, Day, Year). State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 28 2012 ear NICHOLSON APRIL 9:39 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S SPRINGDALE <u>9217 GARY LANE</u> . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖺 F Months Hours Min SEPT Day8 Year 919 TENNE'SSEE 413-22-2850 92 Director Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10c. City, Town or Location the Maryland 10d. Inside City Limits Director 1 XYes 2 No PRINCE GEORGE'S **SPRINGDALE** MD 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral with 9217 GARY LANE 20774 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK "natural", Completed 3 Widowed 4 Divorced Il Hygiene. Other than "natura vent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH DOMESTIC PRIVATE t. Page 1 and 2 should be filed with thrent of Health and Mental Hygien rtant: If item 27 is marked other th jury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CAULIE NICHOLSON GEORGE NICHOLSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9217 GARY LANE SPRINGDALE, MARYLAND 20774 ROSIE WOODRICK/DGT. Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/9/2012 LANDOVER, MARYLAND HARMONY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ HYPERTENSIVE CARDIOVASCULAR DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner HYPERTENSION** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events **DIABETES MELLITUS** and resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 month 1 Yes 2 XNo Ectopic pregnancy ate has been signed by the atte page 2 should be detached for Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CHRONIC KIDNEY DISEASE 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an DEMENTIA has autopsy performed Yes 2 death? 2 No 1 🗌 Yes Yes 25. Was case referred to medica 26. Place of Death (Check only one) funeral director Certificate: To Be examiner? 1 X/es Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work s after death. 1 🗌 Yes 2 🗌 No ☐ Accident completed filled in by the Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year)

9∨

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DRONNE GAY LYNCH 1160 VARNUM STREET NE WASHINGTON, DC 20017

31. Date filed (Month, Day, Year)

Year) 32. Recorner's Signature

1Y 0 9 2012 Person A. Baris

N0315

2012

01

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 2. Date of Death . Decedent's Name (First, Middle, Last) 7:35Am **Physician** 247 /Medical 4b. City, Town, or Location of Death 4c. County of Death Name (If not institution, give street and Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore** If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days 1 5 M 2 - F 70 Director 219-38-9731 July 14,1941 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show the Medical Examiner must be notified at MD 1 Yes 2 No Director Dundalk Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a or 21222 United States 6714 Bessemer Avenue death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
nt; If Item 27 is marked other than "natural", or ite 1 Yes 2 If Yes, Give Year or Dates: X Never Married 2 ☐ Married 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City of Public Works 7 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Agnes Stachorowska Emory Newberger ည other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1809 Clearwood Road Parkville, MD 21234 19a. Informant's Name/Relationship (Type. Print) Mr. Michael J. Mahala (Nephew) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H
Important; If Ite
any Injury or ott 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) 4 \ Donation 5/4/2012 Towson, Maryland Service Corp: 21. Signatu Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused it shock, or heaft vailure. List only one cause on each line. Immediate Cause Final disease or condition resulting in death) Approximate
Interval Between
Poset and Death

AMM complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest **Physician** /Medical or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury) Examine Due to (or as a consequence of) il or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No Yes ng to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contribut 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) Hospital: 1 Yes No Inpatient 2 ER/Outpatient 3 🗀 DOA 6 Other (Specify) Certification: To Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 🗌 No filled in by the Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and

State Registrar

DHMH 17 Rev 1/2001

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 Medical 4a. Facility Name (if not in titution, give street and number) 4c. County of Death 4b. City Town, or Location of Death **Examiner** Baltimore Northwest Seasons Hospice Randallstown Birthpia Country) VA If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthdav. **Funeral** (Month, Day, Y Year 81 Director 227-38-6281 1 X M 2 - F items 23a or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Completed by Funeral Director 1 X Yes 2 No MD NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 USA 3405 N. Hilton Road Apt. #1 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. African 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: American ¾☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade College (1-4 or 5+) Patterson High School NĂ Chief Custodian Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk. ൧ Bell Nollie Laura 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Clayton, NC 27520 600 Boling Street Apt. #35 Kim O. Busby-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 05-15-12 4 Donation 5 Other (Specify) Wylie Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition ce Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. E. ter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Vear Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 20 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 0 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 5 Pending Natural 2 🗌 No Investigation Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practitioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier

N/ U

DHMH 17 Rev 06-2011

State Registrar NAY 0 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ lHOMAS FRANCIS NIBAL MA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death UNIVERSITY TIMORE OF MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Director 212-52-6244 1 🗶 M 2 🗆 F 62 06/16/1949 Usual Residence of Deceden 28a-f show 10c. City, Town or Location 10b. County at Director be notified Parkville MD Baltimore 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a ed other than "natural", or items 23: event, the Medical Examiner must I U.S.A. 2708 Waldor Drive 21234 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 🗷 No Specify: If Yes Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Realtor Real Estate Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ Thomas Conti Nibali Agnes Wohnhaaf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a: If item 27 is Nancy Nibali / Wife 2708 Waldor Drive, Parkville, MD 21234 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Important: If i
any injury or or ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Anataw Gifts Registry 05/07/2012 Hanover, Maryland Signature Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ard disease or condition resulting in death) la Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and I for use as the burial-transit death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown P.0. ed by tl detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Records. Cancer Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No transplant 24a. Was an page 2 s autopsy performed To the Hospital or Attending Physician: of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No ည 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death. To the Funeral Director: After Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division М Accident Investigation 6 Could not be filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vear

10

50 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 X No

Maryland

White

Approximate

Dav

Interval Retween Onset and Death

) mulnutes

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year) MAY 0 9 2012

32. Registraris

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 2, Physician/ 2012 Hoan Nguyen 1:25 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Director 586-40-2955 1 □ M 2 X F 83 Yrs. February 10, 1929 Vietnam show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Maryland Montgomery 1 X Yes 2 No Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 Shipwright Court 20877 United States ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: "natural" Completed 3 X Widowed 4 □ Divorced Asian Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than " Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene 12 0wner Liquor Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) item 27 is marked other traumatic ev ပ Lien Nguyen Bon Tran f Health and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dien Luu / Son 12 Shipwright Court, Gaithersburg, Maryland 20877 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Montgomery or other place) Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 6, 2012 Bethesda, Maryland 21. Sign (ure of Funeral ervice Licensee Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. M01619 7557 Wisconsin Avenue, Bethesda, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Hepatocellular Carcinoma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death 1 Yes 2 9 Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 X No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy performed? Yes 2 X No 2 🗌 No 1 Yes 25. Was case referred to medical examiner? 1 ☐ Yes 2 🕅 No Be 26. Place of Death (Check only one) Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 \sum Yes 2 \sum No Certificate: 28d. Describe how injury occurred 1 X Natural iniury 5 Pending Accident Investigation

goyen, Hoan

eral Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the burial ie Hospital or Attendi n 24 hours after death ie Funeral Director: A To the I within 2 To the I

State

Medical

8600 Old Georgetown Road, Bethesda, Maryland 20814 Yuneng Li, M.D. 32. Regist Ir's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

determined

Suicide

4 Homicide

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

Registrar

K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D67986

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

May 2, 2012

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ F1o Notestine 2012 1:35 Ida May 4, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital 01ney Montgomery 5. Social Security Number If Under Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours Min. (Month, Day, Year) 220-32-7257 1 □ M 2 😿 F Director Usual Residence of Deceder 75 March 17, 1937 West Virginia or 28a-f show notified at 0a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Rockville Maryland Montgomery 10f, Zip Code 0 10e. Street and Number 10g. Citizen of What Country? ms 23a or Funeral 20853 13007 Eloise Avenue United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian an "natural", or itel Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. Completed 3 X Widowed 4 Divorced White Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 11Bookkeeper Furniture Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ other traumatic Grover Baker Ressie Canfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important; If item 27 is any injury or Att. 19916 Sweetgum Circle #12, Germantown, Maryland 20874 Beverly Ward / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 9, 2012 Rockville, Maryland Parklawn Memorial Park 21. Signature of Funeral Service Licensee R<sup>22</sup> Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue,Rockville, Maryland 20850—2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and Due to (or as a consequence of): attending physician Physician/Medical certificate be P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregga 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performed? death? After this certificate Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury 1 Natural Accident
Suicide Investigation completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number Med Dr-10050410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

32. Regist

Porner Philip

20857

Olnes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month liver 0815 AM Denisa MAT Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Balt moize MARZOR Hurp. Wal 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🏲 F MD **Director** 48 Mar 4, 1964 218-82-1353 Yrs. Usual Residence of Deceden 28a-f shov 10a. State 10c. City, Town or Location at within 72 hours after death with the Maryland 10d. Inside City Limits Director notified 1 Yes 2 No **Baltimore Anne Arundel** MD 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 21225 U.S.A. 2805 Round Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. Is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled **Disabled** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Collie Oliver Doris B. Oliver Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 2805 Round Road. Baltimore, MD 21225 Gary Randall, Jr. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗶 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) May 11, 2012 Lansdowne, Maryland Mt. Zion Cemetery 21. Signature of uneral Service Licensee 22. Name and Address of Facility

Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 23a. Part T. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ CARDIAC DYSRHTTHMIA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Aquinen Immre Deticier syndron 1 Yes 2 No 3 Probably 4 Unknown Completed multionspor dystanchion syndrone 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) xaminer? 2 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury hours after death. 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral I

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Prtifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier . 1) DOO 61438 30. Name and a ddress of person who completed cause of death (Item 23a) (Type, Print) 3001 Soft Harover St Boltmore MD 21225 BUKOV.TZ 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Rosa Ottobrini 7:00a M 2012 Medical Mav 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1203 Dublin Court Lutherville Baltimore 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Funeral (Month, Day, Year) 9-18-1917 1 M 2 X F Hours Min 94 Director 213-28-4069 PA Usual Residence of Decedent 28a-f show with the Maryland notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Lutherville 1 Yes 2 XNo 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 1203 Dublin Court 21093 USA 72 hours after death Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify White 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Daroff Company Seamstress 3rd should be filed w n and Mental Hyg Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francesco D'Eramo Anna Disantis 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 is Josephine Persichitti Lutherville, MD 21093 1203 Dublin Ct. permit. Page 1 and 2 Department of Healt Important: If item 2 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State ò Baltimore, MD 5/10/2012 injury ( 4 Donation 5 XOther (Specify) entomb. Lorraine Park Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph N. Zannino Jr.FH 263 Conkling St. Baltimore, MD 21224 S. 23a. Part 1. Esta the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ Concin VWWAR M 2DAIDAIR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Error Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 24 hours after death. France of the speen signed by the set of filed in by the france of filed in by the funeral director, page 2 should be detached? 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Dending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Funer completed fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cectifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item-23a) (Type, Print) PALTIMORE MP 31. Date filed (Month, Day, Year)
NAY 0 9 2012 Registrar

HMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23a per doc g927 5-9-12 vt. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Van Physician/ Owens Ellis :40a 2012 Medical Arvel 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Future Care Nursing Home Reisterstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Davs Hours Director 219-16-5404 Usual Residence of Deceder 1 ▼ M 2 □ F 87 25 b1 04 MD 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland **Funeral Director** notified 1 X Yes 2 No NA Baltimore MD 123a o. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with must ! 21207 U.S.A. 1356 Vida Drive items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 'natural", or 1 Never Married 2 Married Y Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Black 3√ Widowed 4 Divorced Specify: Completed Year or Dates h and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working Aberdeen Proving life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Ground 12th grade Preventitive Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lillis Thomas Charles Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 1356 Vida Drive, Baltimore, Md 21207 Paula Owens-Ashby-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, 5/4/2012 Arburus Memorial Arbutus, Md 21. Signature of your leral Service Lig 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, md 21215 23a. Part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Senile Dementia Integal Petween Oaset and Death Physician/ Haut disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as nding IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death ed by the a detached f been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 🔀 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Investigation Accident in by the 24 hours after deal Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 037573 2012 30. Name and address of person who complete of death (Item 23a) (Type, Print) cause

Registrar
DHMH 17 Rev 06-2011

State

Jeffrey

Zibel

MAY 0 9 201

835

Ave, Suite 203, Baltimore,

Md

Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04 Physician/ <sup>D</sup>27 3:07 A.M Frank Pearson 20°1 2 Carev Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Upper Marlboro Prince Georges 12101 Hartland Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) MI Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 D F 579-56-7428 07/08/1941 70 Director Usual Residence of Decedent or 28a-f show 10h. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Upper Marlboro P.G. 1 X Yes 2 □ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20772 United States 12101 Hartland Road items death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married "natural", or <u>ک</u> within 72 hours after Maryland 21215-0036 Black 1 ☐ Yes 2X No Specify. Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) 12th College (1-4 or 5+) Foreman Construction any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Douglas Pearson Yarborough Estelle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn F. Pearson/wife 12101 Hartland RD., Upper Marlboro, MD. 20772 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake 20a. Method of Disposition 20c. Location - City or Town, State Department of 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State Beltsville, MD 5/2/2012 **Important**: 4 ☐ Donation 5 ☐ Other (Specify) 420 H Street NE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility B.K. Henry Funeral Home Wash., DC.20002 enri Part 1. Enter the disease, or complications shock, or heart failure. List only one cause of aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death signed by the a d be detached f Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ The law requires Division of Vital Records, cate has been sig page 2 should b 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 🗌 Yes 2 🗌 No To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 1 No မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Director: After 5 Pending death. 1 🗆 Yes 2 🗆 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Sm 0 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

amend 28a-b, per me, g927 5-30-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

**Baltimore** 

Months Days

7. Age (In yrs. last birthday)

4b. Lity, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Birthplace (State or Foreign Country)

10d. Inside City Limits

Pennsylvania

March 27,1921

4940 Eastern Avenue, Baltimore, MD, 21224

|           |   | Physici<br>/Medic<br>Examin<br>Funeral<br>Director   | an<br>cal<br>ier            |
|-----------|---|--|-----------------------------|
| 1215-0036 | vithin 72 hours after death with the Maryland | ne.<br>han "natural", or items 23a or 28a-f show<br>• Medical Examiner must be notified at | mpleted by Funeral Director |

For State Registrar

5. Social Security Number

10a State

214-12-9690

Usual Residence of Decedent

Stephen Thomas 4a. Facility Name (If not institution, give street and number,

Johns Hopkins Bayview Medical Center

6. Sex

1 X M 2 □ F

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene, Important: If item 27 is marked other than any lijury or other traumatic event, the Mang, injury or other traumatic event, the Monce.

Baltimore, Maryland

**Physician** /Medical Examiner

The law requires that the death certificate be executed nding physician and use as the burial-trar the signed by Division of Vital Records, has this certificate or Attending Parter death.

Director: After to

Box 68760,

P.0.

completely filled in by the funeral e Funeral I To the Hospital within 2 To the I

State Registrar

10c. City, Town or Location 10b. County 1 Yes 2 X No MD Baltimore Dunda1k 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 7330 Kirtley Road 21224 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1x Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: 3X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Years Pressman Paper Company ပိ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Oles John Radomsky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1725 Ranch Lane Baltimore, Maryland James J. Radomsky (Nephew) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State Bel Air Mem. Gdns. 4 □ Donation 5 ▼ Other (Specify) Entombment 5/7/2012 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 art 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final raumatic disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ntracerebra that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant ate of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: Injury unknown 4/25/70 Pay Year) 1 Natural 5 Pending investigation fall 1 ☐ Yes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1830 KYF124 FOUL determined 4 Homicide Home Pundalk, MO 29a. Certifier (check only 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d, Date signed (Month, Day, Year) RES-000 2,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001 11595

wang

a

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                            |   |              |  | State of Maryland / D   |  | nd Mental Hygier                                | ne 2012 11.00   | ) (      |
|----------------------------|---|--------------|--|---|--|---|---|----------|
|                            |   | _            | State Registrar  | (   | Certificate of Death   | Reg.  |   | 10       |
| 5.44                       | Physicia<br>Medi  | cal          | 1. Decedent's Name (First, Middle, Last)  Sign VCS+CV  4a. Facility Name (if not institution, give str                                 | and and aventory  | Ruffin   |   | Day 12 Year   3. Time of Death   18:33 M  | VI       |
| wall.                      | Examir<br>  | ner          | The Johns Ho.  | phins Hospital  | 46, City, Town, or Location of Pathmore  | City  | 4c. County of Death   |          |
|                            | Funeral<br>Director   |              | 5. Social Security Number  3-31-40-0046  Usual Residence of Decedent  6. Sex  1 ☑  | 7. Age (In yrs. last birtho   | Months Days Hours  | 4 Hrs. 8. Date of Birth (Month, Day, Yea 9-3/-/ | 9. Birthplace (State or Foreign<br>Country)   | ın       |
|                            | Maryland<br>28a-f shor<br>otified at  | Director     | 10a. State 10b. County  Balty  | nove hind   | 00 11  |   | 10d. Inside City Limits<br>1 ☐ Yes 2 ੴ  |          |
|                            | is 23a or 3   | Funeral Di   | 10e. Street and Number 2 Dell Cod  | irt   | 10f. Zip Code 2124   | 10g.  | Citizen of What Country?  |          |
| 900                        | filed within 72 hours after death with the Maryland fled within 72 hours after Hygiene.  40 other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at  | by           | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.  | 13. Was Decedent of Hispanic Origin If Yes, specify Cuban Mexican,  1 ☐ Yes 2 ☐ No Specify:    | n? (Specify Yes or No-<br>Puerto Rican, etc.)   | 14. Race - American Indian,<br>Black, White, etc.<br>Specify: Black                         |          |
| 212                        | l within 72 hor<br>/giene.<br>ner than "nat<br>t, the Medica  | e Completed  | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)  | completed) (C   | ecedent's Usual Occupation<br>Sive kind of work done during most of<br>fe, DO NOT use retired) | of working 16b                                  | o. Kind of Business/Industry  Tansportation   |          |
| <u>a</u>                   |   | To Be        | 17. Father's Name (First, Middle Last) Ocie L. Ru +  | Fin, Sr.  | 18. Mother   | 's Name (First, Middle, Maide                   | en Surname)<br>UNNEC  |          |
|                            | 1 and 2 should b<br>if Health and Mer<br>item 27 is mark<br>other traumatic   |              | 19a. Informant's Name/Relationship Type,   | Fin/Wife 2  | Mailing Address (Street and Number   | Windsor   | Mill MD 21244   | /        |
|                            | Page<br>ant: If<br>any or   |              | 20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)   | moval from State 20b. Place of D  |  | -10-2012 F                                      | . Location - Eity or Town, State<br>Kesville MD   |          |
| Bal                        | permit. Departr Import any inj  |              | 21. Signature of Funeral Service Licensee  | Gure  | 22. Name and division of Facility 8728 Liberty   | Road Randa                                      | rené Funeral Service<br>115 town, MD 21133  | క        |
| Р                          | hysician/   |              | 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one of immediate Cause (Final disease or condition | ations that caused the death. Do not eause on each line.  | enter the mode of dying, such as ca  | ardiac of respiratory arrest,                   | Approximate<br>Interval Between<br>Onset and Death  | ų        |
|                            | Medical<br>Examiner   | J.           | resulting in death)  Sequentially list conditions, b.  | ue to (or as a consequence of):   |  |   |   |          |
| \$                         | and<br>transit  | Examiner     | if any, leading to immediate   | Due to (or as a consequence of):  |  |   |   |          |
| 09                         | ate be executed<br>physician and<br>the burial-transit  | dical E      | resulting in death) Last   | Due to (or as a consequence of):  |  |   |   |          |
| . Box 687                  | in the transfer of a witerburg Frigstrain: The law requires that the train certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transfer. |              | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown   | If yes, outcome of pregnancy  1 Live Birth 2 Fetal death  4 Pregnant at time of death  9 Unknown                      | 3 ☐ Ectopic pregnancy<br>5 ☐ Other (specify)   |   | 23d. Date of delivery<br>Month Day Year   |          |
| ds, P.O.                   | been signed be should be deta   | ted by P     | Part II. Other significant conditions contr  | buting to death but not resulting in t  | he underlying cause given in Part I.   |   | o use contribute to the cause of death?   | 'n       |
| Division of Vital Records, | iysician: The law renis certificate has be director, page 2 sh  | Completed by | 25. Was case referred to medical   |   |  | 24a. Was an autopsy performed                   | 24b. Were autopsy findings available prior to completion of cause of death?  No 1  Yes 2 No |          |
| /ita                       | s certi   | To Be        | examiner?  | pital:  | 26. Place of Death Other:  |   |   | -        |
| of                         | After this funeral di   |              | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending  | 28a. Date of injury (Month, Day, Year)  28b. Tim inju   | e of 28c. Injury at  | ing Home 5 Residence 28d. Describe how inj      |   | _        |
| ivisior                    | to use in 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral properties.  | Certificate: | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined  | 28f. Location (Street City or Town, Ste   | and Number or Rural Route Number,<br>ate)  |   |   |          |
|                            | e nospita<br>n 24 hours<br>le Funeral   | Medical      | (Citeck Z in Medical Examiner:   | n: To the best of my knowledge, dea<br>On the basis of examination and/or in<br>ractitioner: To the best of my knowle | ivestidation, in my opinion, death occi.   | irred at the time, date and bla                 | ice, and due to the cause(s) and manner stati   | ted.     |
| , i                        | Within Comp   |              | 29b. Signature and title of certifier  | 12.1.   | 29c. License number  | 29d. I  | Date signed (Month, Day, Year)  | $\neg$   |
|                            | 3   |              | 30. Name and address of person who com   | Deted cause of death (Item 23a) (Typ  | rkes-Doo   | j m   | ay5,2012  | $\dashv$ |
|                            | 7   |              | 1.4 4. 5 4. 5  | 32. Registrar's Signature   | 1000 MOAH WO   | fe Orrect, Bi                                   | attimore mo 21287   | _        |
|                            | Stat<br>Registra  |              | MAY 0 9 2012 Sense   | S. Haves  | )  |   |   |          |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Month Rass Medical Dougles 2017 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hesp- (~1 adultitue. Next - ren 7. Age (In vrs. last birthday) Year If Under 24 Hrs. If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Months Min 1 🗆 M 2 🗷 F **Director** 68 Usual Residence e of Decedent 28a-f show at 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** notified MD 1 Yes 2 No 6 10g. Citizen of What Country? must be n 21207 USA items death 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married within 72 hours after 3lac If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", Completed 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT Elementary/Secondary (0-12) Be be filed v Maryland Father's Name (First, Middle, Last) and Mental F is marked o ပ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. eonara Baltimore, Method of Disposition 20b, Place of Disposition cemetery, cremator 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Entect he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Myo co-A- =1 Medical resulting in death) Due to (or as a consequer Examiner Corp. orgopula Zichen-c Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) the Hospital or Attending Physician: The law requires that the death in 24 hours after death. the Puneral Director: After this certificate has been signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \( \tau \) Nursing Home \( 5 \tau \) Residence \( 6 \tau \) Other (Specify) 2/ No 1 Yes ပ Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Natural Accident 1 Yes 2 No Investigation completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29085 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21133 7-

State Registrar 31. Date filed (Month, Day, Year) MAY 0 9 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 11:10 PM Edward A. Rowlette Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGNES ALTIMORE HOSPITA Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Social Security Number 24, 1964 April MD 218-88-9538 48 Director 1**X** M 2 □ F Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director MD Baltimore notified 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 5 10g. Citizen of What Country? ms 23a or must be n Funeral 1729 Rutland Ave 21213 USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Examiner Black, White, etc. or þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify:Black and Mental Hygiene.
is marked other than "natural",
aumatic event, the Medical Exa 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry
Baltimore City 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Solid Waste 8th aborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Randolph Rowlette Sr Josephine Smith other traumatic and 2 should b Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adrienne Rowlette (sister) 1729 Rutland Ave. Balto, Md. 21213 If item 27 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date j<sub>o</sub> crematory or other place, 1 Burial 2 X Cremation 3 Removal from State injury or Department Important: If any injury or Green Mount Crema.. May 14,2012 Balto, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Function & License 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home
1412 E. Preston St. Balto, Md. Name and Address of Facility 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ph si i n METASTATIC HEPATO CELLULAR MONTHS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s has autopsy performed After this certificate Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) or Attending Physician; Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation within 24 hours after death To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar S. CATON AVE.

BALTIMORE

RONQUIL

Ō

900

JONATHAN

31. Date filed (Month, Day)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Υ. Rizkalla 6. 2012 Mary May 9:03  $A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 220 North Van Buren Street Rockville 5 Social Security Number 8. Date of Birth (Month, Day, Yea April 10, 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Months Days Hours Min. Year) 1921 Country)
Egypt Director 220-98-6198 91 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits with the Maryland Director 1 X Yes 2 No Rockville Montgomery Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 220 North Van Buren Street United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes Give 3 XWidowed 4 ☐ Divorced Specify Completed Year or Dates. White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 all Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Education Music Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Regina Kevorkian Youssef Meguerdijian and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a Nasr E. Rizkalla / Son 303 Luckett Street, Rockville, Maryland 20850 20b. Place of Disposition (Name of Garetery, or many and the place)
Mausoleum 20a Method of Disposition 20c. Location - City or Town, State Page 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ② Other (Specify) Entombrent permit. Page Department of Important: If any injury or May 8, 2012 Silver Spring, Maryland 21. Signature of Funeral Service bicensee Robert Adres Pulliphrey Funeral Home/Rockville, Inc. the Fr 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Bladder Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury that initiated events Hematuria pue Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as IE FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death the a 1 Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Failure to Thrive, Hypertension 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available 24a. Was an or Attending Physician; The law this certificate has prior to completion of cause of death? S autons page perform Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Certificate: X Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 29a. Certifier 🛚 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Norse Plactioner: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner stated. 29b. Signature and title of certif D0057574 May 7, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. 2401 Research Boulevard, Rockville, Maryland 20850 Ahmed Heshmat, M.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Robert Clayton Randall May 2012 9:16 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Min Director 577-44-6373 1 X M 2 □ F 77 January 18, 1935 Washington, D.C. Usual Residence of Decedent 28a-f short 10a, State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Rockville 1 X Yes 2 No 10e. Street and Number or items 23a or 10g. Citizen of What Country? Completed by Funeral 14411 Traville Garden Circle, B302 United States 20850 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces?
X Yes 2 No 1952-Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 □ Divorced Specify: White 1956 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Stock Broker Investments Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Thomas King Randall permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. Kathryn Albaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Vezzi /Daughter 10810 Burbank Drive, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Montgomery Crematorium, Inc May 9, 2012 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lic Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Eyer the disease, or complications that caused shock, or heart failure. List only one cause on each line er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ cardiac arrhythmia Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 use ρ á þ

Completed page 2 should Be မှ Certificate: filled in by the 24 hours after deat Funeral Director:

| FEMALE:  Bb. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown | 23c. If yes, outcome of pregnancy  1  Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown | h 3 Ectopic pregnancy 5 Other (specify)           |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|
| Atrial F  | contributing to death but not resulting in brillastion   | in the underlying cause given in Part I.          |  | se contribute to the cause of death?   |  |  |  |  |
| hiver mo  | CSS  |   | 24a. Was an autopsy performed? 1  Yes 2 Yeno                                   | 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No |  |  |  |  |
| . Was case referred to medical examiner?  |  | 26. Place of Death (Check only one)               |  |  |  |  |  |  |
| 1 Yes 2 No  | Hospital: 1 Dippatient 2 ER/Ou   | utpatient 3 DOA Other: 4 Nursing H                | ome 5 Residence 6  | Other (Specify)  |  |  |  |  |
| 7. Manner of Death 1  | (Month, Day, Year) i   | Fime of njury at work?  M 1 Yes 2 No              | 28d. Describe how injury   | occurred   |  |  |  |  |
|   |  | 28f. Location (Street and<br>City or Town, State) | 8f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |  |  |  |  |  |
| la. Certifier (Check only one)  1   |  |   |  |  |  |  |  |  |

29c. License number

D0064418

within 2

To the I

Medical

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Yea State MAY 0 9 2012

9901 medical Car or Rockville MD 2000

29d. Date signed (Month, Day, Year) May 7,2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5:15PM ZO. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Manor Care Ruxton Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 🗌 N 102 214-58-7307 Director April 24,1910 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show notified at Director 1 ☐ Yes 2XXVo MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or adical Examiner must be 2667 Legends Way 21042 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2XX If Yes, Give Year or Dates: 1 Never Married 2 Married 0 1 ☐ Yes 2X No Specify: Specify: White ģ 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homenaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Lechert Helen Wesolek 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (9) Patricia Hupfer — Daughter 2667 Legends Way, Ellicott City, Maryland 21042 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State May 10, 2012 Baltimore, Maryland 4 Donation 5 Dother (Specify) Cardens of Faith Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services — Parkville 8800 Harford Road, Parkville, Maryland 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 Who 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

death certificate be executed P.0. or Vital Records,

Maryland 21215-0036

Baltimore,

and 2 should be

permit. Pages 1 and 2 Department of Health a

signed by t d be detach cate has l certificate Physician: this After Division Attending ours after death.

neral Director: A
filled in by the fu ō within 24 hours a To the Funeral 1 To the Hospital

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) Jal eath (Item 23a) (Type/Print) (Month, Day, State Registrar DHMH 17 Rev 1/2001

29a, Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Cu-ROUGHTVEOT ANOERS 1823 2011 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** 4c. County of Death hospida altimor Social Security 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. mber If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min -44-9661 Director 1 **X**M 2 □ F JUNE 9, 1944 NY 28a-f shov 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director BALTIMORE CATONSVILLE MD1 Yes 2 No 10e. Street and Number ō items 23a or ner must be n 10g. Citizen of What Country? 1502 FREDERICK ROAD 4. 5. A **ス1228** 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. Armed Pulces.

Xes 2 No

If Yes, Give June 18 1963

Year or Dates June 17 1967 5 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify: WHITE Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) DRIVER TRUCKING TRUCK 12 other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisherships is marked of OLAF ANDERS ROUGHT VEDT SR. ROSE MARSA 19a. Informant's Name/Relationship (Type, Print) Son/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 strict of Health a: ANOERS ROYCHTVEOT 8612 GLENN HANNA CT BALTIMORE MO 21244 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State (of F 1 Burial 2 Cremation 3 Removal from State Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) ARDENT CREMATION MAY 8, 2012 HANOVER . MO 21. Signal e f Fun Service Livence JOSEPH L. CAMBY 22. Name and Address of Facility MARZULLO FUNERAL CHAPEL 6009 HARFORD ROAD BALTIMORE MO 21214 and 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, flock, or heart failure. List only one cause on each line. nediate Cause (Final Onset and Death Physician/ negative Sep 81 1 risease or condition resulting in death) Gram Medical Due to (or as a consequence of). Examiner 16 alee sho cle northad Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events an who peur and resulting in death) Last Due to (or as a consequence of) burialphysician the burial Physician/Medical Records, 4.0. Box 68760 IF FEMALE: sought red nse 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ for in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes No Hospital or Attending Physician; The 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1- Natural (Month, Day, Year) 5 Pending after death. Director: Af 2 Accident
3 Suicide
4 Homicide M 1 Yes 2 No Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 To the I 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) atkener P26618 ame and address of person who completed cause of death (Item 23a) (Type, Print Bal himox et Kumar 900, S caron AVR 21229 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Odelle 5:51 CIM Reed 5015 April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Mayland Medical Center Baltimore University 01 If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 8. Date of Birth **Funeral** 5 Social Security Number 226-50-8732 (Month, Day, Year) Hours Min. **Director** 1 XM 2 X F 06/01/1939 Virginia 72 ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1x Yes 2 ☐ No N/A Baltimore MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1 and 2 should be filed within 72 hours after death with of Health and Mental Hygiene. The train of a 23a often 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must b. U.S.A. 21223 4th Floor 109 N. Carey St. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2X No Yes, Give 1 Never Married 2 XMarried þ Maryland 21215-0036 1 Yes No Specify SpecifyBlack 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12th Grade College (1-4 or 5+) Bank Computer Processor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Unk Savannah Reeves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 109 N Carey St. 4th Floor, Balto., MD 21223 Trecie Reed(wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once: 1 Burial 2 X Cremation 3 Removal from State on-site Crematory 04/13/12 Baltimore, MD 4 Donation 5 Other (Specify) 21. Sign-Lire of Funeral Service License Foreight of Brown Jr. Funeral Home PA MD21217 2140 N. Fulton Ave., Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Intra chania Hemounage disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ON AVEROVED BY MEDICAL EXAMINER Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Directo for as a consequence of Exami Cause (Disease or injury that initiated events resulting in death) Last the burial-tran CERTIFICAT Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna5 Other (specify) Ectopic pregnancy After this certificate has been signed by the atter-funeral director, page 2 should be detached for in the past 12 months? Month Day Year ☐ Pregnant at time of death☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 4 completely filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical 1 X Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After Natural injury work? 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner. To the best of ny knowledge or all occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29c. License number M. D 1003115569 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

leongae

31. Date filed (Month, Day, Year)

MAY 09

Youn

2

32 Registrar's Signature

park

Cireene

Baltimore

21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 23a per dr., g927,05/09/2012dhb
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1:30 P Edmond 2012 Register A pri Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore washington medical Center Buchi 6len Anne Arunder If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Months Hours Country) **Director** 1 XM 2 🗆 F 215-56-5105 Usual Residence of Deced Yrs. 61 July 11,1950 Maryland show 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits notified at **Funeral Director** 28a-f 1 Yes 2 No Maryland Anne Arundel Pasadena 0 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 93 Will-O-Brook Drive 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black White etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. Specify 3 Widowed 4 Divorced Completed White Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Edmana 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Contractor Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked o ည Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health at Important: If item 27 is any injury or other trau once. Deborah A. Register - Wife 93 Will-O-Brook Dr., Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Metro Crematory April 16,2012 Baltimore, MD 21. Signature of Funeral Service Lig 22. Name and Address of Facility 3111 Mountain Rd., Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph\_sician/ Medical resulting in death) as a consequence of) Examiner Coronary Artery Disease Securitistly list ecodition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami and -trar that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a ched for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Month Year 9 Unknowe been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Record 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed To the Hospital or Attending Physician: The certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 🔲 Yes 2 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4  $\square$  Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 0032744 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 30 MD

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <sup>2</sup>012 9 AM May Evelyn Agnes Shettle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Catonsville Baltimore 302 Stonewall Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral Director** 1 🗆 M 2 🔽 218-05-7999 93 3/9/1919 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at **Funeral Director** 1 Yes 2 No MD Catonsville Baltimore 10e Street and Numbe 10f. Zip Code ms 23a or must be n 0 10g. Citizen of What Country? Stonewall 21228 302 Rd death "natural", or iterr ledical Examiner 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 ₩ Widowed 4 Divorced White Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Own Home Homemaker other 1.2 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H
fitem 27 is marked ot
r other traumatic even မ Helen (nee Johnson) Riesler E. Stanley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Stonewall Rd Catonsville MD 21228 Mary Frederick 302 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial 5/12/12 Balto MD 21. Signature of Funeral Service Lidenses 22kussells Craig Witzke Funerals & Cremations 9Newburg Ave Catonsville, MD ₽A 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death CVA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner I weel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy for in the past 12 months? Month Day 5 Other (specify) Year Pregnant at time of death ed by the al Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ₽ 1 🗌 Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of each 3 Certifying Marse Practitioner: To the b Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month. Day, Year 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOLID. ELLICOTT CITY 10299 SHEEMAN Chaples State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ammend items 17.18 per fh g931 9-27-12 vt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mav Eshrat Douzande Shafazand 201 7:26 P. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Genesis Cromwell Baltimore Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth
(Month, Day, Yea
Feb. 3. 1 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔽 F Hours Director 167-60-8867 95 1917 Iran Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔯 No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11729 Mayfair Field Drive 21093 Iran Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 3 🛱 Widowed 4 □ Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Megones. Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Homemaker Own Home Be 17. Father's Name (First, Middle, Last)
Gholamreza 18. Mother's Name (First, Middle, Maiden Surname) မ Douzande unk-Sakeeneh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nina Nasseri (daughter) 11729 Mayfair Field Drive Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. Grdns. 5-11-12 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility.
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician a ALZITEIMER'S DISEASE disease or condition resulting in death) END Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the attending physician and thed for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 Be 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) 2 1 No Other: ၉ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pendina 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Deficiency in State and place, and due to the cause(s) and manner stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 032717 0000 82 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8710 EMGE RD BALTIMONE MY 21236 FERNANGO DELGADO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #26 Per PHY G927 5/09/2012 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August Andrew Solomon Medical May 2012 2:10A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7414 Poplar Avenue Dunda1k Baltimore Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) Months Days Min Hours (Month, Day, Year) Director 176-14-6931 1 5 M 2 - F 91 Yrs. March 17,1921 PA Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at Director 10d. Inside City Limits 1 Yes 2 XNo Baltimore Dunda1k or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 7414 Poplar Avenue 21224 United States items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ö þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Year or Dates. WWII "natural", Completed 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+)
Years 12 Years Electronic Technician Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental } ဂ္ Mary Ivan Michael Solomon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1104 Armstead Street Glen Burnie, MD 21061 item 27 Alan R. Solomon (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/7/2012 Glen Burnie, MD Glen Haven Cemetery 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dundalk Maryland 2122 Justin Jones 21. Signature of Funeral Service Licensee 7922 Wise Ave. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, that only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ obstruction disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Starte for ea a consequence of Cause (Disease or injury that initiated events and burial-trar resulting in death) Last Due to (or as a consequence of): physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ò in the past 12 months? Pregnant at time of death Month Day Year signed by the at d be detached for 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ lever desease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Attending Physician: The law has autopsy Deventra performe this certificate 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home XX Residence 2 W/V 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending I or Attendi s after death. I Director: A d in by the fi ☐ Acciden
☐ Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after

To the Funeral Direct

completely filled in by the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier မ 29d. Date signed (Month, Day, Year) 03 D21846 2012 rol 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospita Steloa 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Registrar DHMH 17 Rev 1/2001

State

Name and addr

31. Date filed (Month. Day.

MAY 0 9 2012

Year

8415

Bellong Lane Towson, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ma 15 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death 420 more If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Min **Director** 1 M 2 XF 30 unk Usual Re 28a-f shov 10a. State must be notified at 10b, Count 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 es 2 No TIMORE 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 21201 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 2 No 1 ☐ Yes 2 No Specify: 3 Nidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number Wenise Vto. 4202 Carigirer 20c. 20a. Method of Disposition 20b. Place of Disposition (Name of Date Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory 21. Signature of Funeral Service Lice sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final Onset and Death BIAL Physician/ disease or condition Medical resulting in death) to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown the a 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the director, page 2 s autopsy 2 No Yes 2 No 1 🗌 Yes director. 25. Was case referred to medical To Be 26. Place of Death (Check only one) UROUP H Hospital 1 ☐ Yes 2 No Other: 4 🗌 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 K Other (Specifi funeral 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After t Certificate: 28d. Describe how injury occurred Natural 5 Pending injury after death.

Director: Aft Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined 24 hours : Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hor To the Fune completely f (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year,

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ -100 P M 7 2012 Stokes <u>Anita</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bouthmore Sinai Hospital 01 Baltimore If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 8. Date of Birth 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Country) 1 M 2 F 214-38-7287 Director 10 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits at 10a. State Director other traumatic event, the Medical Examiner must be notified 1 X Yes 2 No Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? o 10e. Street and Number 23a U.S.A. 21207 2202 Wheatley Drive Apt 202 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72! h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Bar Bar Maid 8th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mattie Crawley Samuel Gee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt 20 Department of Health and Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 2202 Wheatley Drive, Baltimore, Md Bernadette Goodman--Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Woodlawn, Md Woodlawn 5/11/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility March F/H West 14300 Wabash Av 21. Signature of Fundal Service Lin Baltimore, 21215 Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BRAIN ANOXIC NJUFU disease or condition Medical resulting in death) Due to (or as a consequence of): DAYS Examiner ARDIAC Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit APTER CORONARY Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hyperlipidemia To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an kina DISEARC autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 [ 3 [ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MBBS 2012 address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year,

SINAI

Banavau

HUSPITAL

OF

Steinacker, Joyce
Baltimore, Maryland 21215-0036

|  |  |                                  | For  |                                     | State of                                   | Marylar          | nd / Depa                         |                             |                        |                          | and M                    | lental Hy                       | giene                     | 9 00                       |                         |                          | 7 1            |
|--|--|----------------------------------|--|-------------------------------------|--|------------------|-----------------------------------|-----------------------------|------------------------|--------------------------|--------------------------|---------------------------------|---------------------------|----------------------------|-------------------------|--------------------------|----------------|
|  |  | _1                               | - State<br>Registrar   |                                     |  |                  | Cer                               | tificate                    | of E                   | Death                    |                          |                                 | Reg. No                   | <u>. 20</u>                | 112                     |                          | <u> </u>       |
| Phys   | sician                                   |                                  | 1. Decedent's Name (First, Middle, Last)   |                                     |  |                  |                                   |                             |                        |                          |                          | 2. Date of Death Menth Day Year |                           |                            |                         |                          | of Death       |
| M  | edica                                    | II.                              | Joyce ta. Facility Name (if  |                                     | einacker                                   | 10.5             |                                   | I                           |                        |                          | (0 "                     | May                             |                           | 4 2                        | 019                     | U7:1                     | 0/4 M          |
| Exa  | mine                                     |                                  | Baltimo  |                                     |  |                  | antar                             | - 1                         |                        | Buch                     |                          | 7                               | 40                        | Ann                        |                         | rund                     | 0/             |
| Fune   | eral                                     |                                  | 5. Social Security N   |                                     |  | Age (In yrs.     |                                   | If Under                    | 1 Year                 | If Under                 | 24 Hrs.                  | 8. Date of Bir                  |                           | 11/1///                    | g. Birthp               | ace (State               |                |
| Direc  |  |                                  | 217-40-3   |                                     | 1 □ M <b>XX</b> F                          | 70               | Yrs.                              | Months !                    | Days                   | Hours                    | Min.                     | (Month, Da<br>7/31/1            | ay, Year)<br>L <b>941</b> |                            | Count                   | <sup>ry)</sup> MD        |                |
| land   | 5 3                                      | 5                                | Usual Residence of 10a. State  | 10b. County                         |  | 10c. Ci          | ty, Town or Loc                   | cation                      |                        |                          |                          | _                               |                           |                            | 10                      | d. Inside (              | City Limits    |
| th the Maryland  | Diroctor at                              | 20                               | MD   | Anne A                              | rundel                                     | G:               | len Bur                           | nie                         |                        |                          |                          |                                 |                           |                            |                         | 1 🗌 Ye                   | s XX No        |
| the N  |  |                                  | I 0e. Street and Nur   | nber                                |  |                  |                                   | 10f. Zip                    | Code                   |                          |                          |                                 | 10g. C                    | itizen of W                | hat Count               | ry?                      |                |
| 21215-0036 within 72 hours after death with the Maryland giene.                          | le l |                                  | 10 Woods   | Ave                                 |  |                  |                                   | 210                         |                        |                          |                          |                                 | US                        | Α                          |                         |                          |                |
| er deat  |  |                                  | 1 Never Marr   | ied 2 <b>XX</b> Married             | 12. Was Deced                              | es?              |                                   | Vas Decede<br>Yes, speci    | ent of His<br>fy Cubar | spanic Ori<br>n, Mexican | gin? (Spe<br>n, Puerto l | cify Yes or No-<br>Rican, etc.) |                           | 14. Race<br>Black          | - America<br>, White, e |                          |                |
| 036<br>s afte<br>ral", c   | Pa Pa                                    |                                  | 3 Widowed  |                                     | 1 Yes If Yes, Give<br>Year or Date         |                  | 1                                 | ☐ Yes 🔏                     | <b>X</b> No            | Specify:                 |                          |                                 |                           | Specify:                   | Whi                     | te                       |                |
| 21215-0036 within 72 hours after giene.  | Ompleted                                 |                                  | (Spe   | 15. Decedent's cify only highest of |  |                  | 16a. Deced                        | ent's Usua<br>and of work   | Occupa                 | ation                    | t of workir              | na .                            | 16b. k                    | Kind of Bus                | siness/Ind              | ustry                    |                |
| thin 73  |  | 5                                | Elementary/Seco  |                                     | College (1-4                               | or 5+)           | life. Do                          | O NOT use                   | retired)               | army moor                | 0, 4,0,1,1,1             | ·g                              |                           | 0                          | TT                      |                          |                |
|  | Bo C                                     |                                  | 7. Father's Name (   | First, Middle, Last                 | )  |                  | Hom                               | emake                       | r                      | 18 Mothe                 | er's Name                | (First, Middle,                 | Maiden                    | Own                        | ноте                    |                          |                |
| arylanc  | 1  | >                                | Raymond  | Ensey                               |  |                  |                                   |                             |                        | Ann                      | _                        | Smith                           | maiden                    | ourname                    |                         |                          |                |
| 10 E E S   |  |                                  | 19a. Informant's Na  |                                     | Type, Print) Hus                           | sband            | 19b. Mailin                       | g Address                   | (Street a              |                          |                          | Route Numbe                     | er, City or               | r Town, Sta                | ate, Zip C              | ode)                     |                |
| re, M<br>1 and 2 s<br>of Health<br>item 27   |  |                                  | Mr. Will   | iam Stei                            |  |                  |                                   | loods                       |                        | G1                       | en B                     | urnie,                          | MD :                      | 21061                      |                         |                          |                |
| 0 5 5  | 5  | 2                                | 0a. Method of Disp.<br>1 ☐ Burial 🕱  |                                     | ☐ Removal from S                           |                  | Place of Dispo:<br>cemetery, crem | sition (Nam<br>natory or ot | e of<br>her place      | e)                       | D                        | ate                             | 20c. L                    | ocation - (                | City or Tov             | vn, State                |                |
| Baltimor   |  |                                  | 4 ☐ Donation<br>21. Signature of Fu  | 5 Other (Spec                       |  | At:              | lantic                            | Crema                       | tory                   |                          | 5/8/                     |                                 |                           | en Bu                      |                         |                          |                |
| Balt<br>permit.<br>Departi<br>Import   | once,                                    |                                  | 21. Signature of 70  | neral S                             |  | 01220            |                                   |                             |                        |                          |                          | gleton<br>Ave SW                |                           |                            |                         |                          |                |
|  |  | +                                | 23a. Part 1. Enter t   | he disease, er o                    | nplications that ca                        | used the deat    |                                   |                             |                        |                          |                          |                                 |                           |                            |                         | Approxima                | ite            |
| Physici:   | an/                                      |                                  | snock, or neal<br>Immediate Cause (<br>disease or conditio                               | Final                               | one cause on each                          | ine.             | on'a                              |                             |                        |                          |                          |                                 |                           |                            |                         | Interval Be<br>Onset and | tween<br>Death |
| Medi<br>Exami  | cal                                      |                                  | resulting in death)  |                                     | a. Due to (or                              | as a consequ     | uence of):                        |                             | n                      |                          |                          |                                 |                           |                            | $\neg$                  | a ju                     | 7-3            |
| Exami  |  | .                                | Sequentially list co   | nditions,                           | b  | 5/21/0           | 4019                              | Fa                          | lin                    | $e_{-}$                  |                          |                                 |                           |                            | _                       | hon                      | 15             |
| de de  | Examiner                                 | t                                | Sequentially list co<br>If any, leading to in<br>cause. Enter Under<br>Cause (Disease or | mediate<br>rlying<br>injury         | Diwite (or                                 | a consequ        | uence of):                        | 1.11                        |                        | hah                      | 04                       | lena                            | 15                        | 1000                       | )                       | 1 11                     | 21-            |
| xecut  | EX                                       |                                  | that initiated events<br>resulting in death) I   | s i                                 | C. Due to (or                              | as a donsequ     | uence of):                        | 191                         | n D                    | 77671                    | 101                      | (110)                           | 7.21 31. 7                |                            |                         |                          | eovr           |
| 60 At ate be executed hysician and the burial-transit                                    | legical                                  |                                  |  | •                                   | d  |                  |                                   |                             |                        |                          |                          |                                 |                           |                            |                         |                          |                |
| 4876<br>tificat<br>ing ph  | Σ  |                                  | F FEMALE:  |                                     |  |                  |                                   |                             |                        |                          |                          |                                 |                           |                            |                         |                          |                |
| Box 687 death certific he attending I  | jan/                                     | 2                                | 3b. Was decedent in the past 12 r  | months?                             |  | rth 2 🗌 Feta     | al death 3 🗌                      |                             |                        | /                        |                          |                                 |                           | 23d. Date<br>Mont          |                         | y<br>Day                 | Year           |
| BC le dea  | Vsic                                     |                                  | 1 Yes 2 Unknown  | No                                  | 4 ☐ Pregna<br>9 ☐ Unkno                    | ent at time of o | death 5 ∟                         | Other (spe                  | ecify)                 |                          |                          |                                 |                           | WOIT                       |                         | Эау                      | real           |
| P,O, that the theorem of the detay.  | Completed by Physician/M                 | F                                | art II. Other signif   | icant conditions                    | contributing to dea                        | th but not res   | sulting in the u                  | nderlying ca                | ause give              | en in Part I             |                          | 23e. Did to                     | obacco ı                  | use contrib                | ute to the              | cause of                 | death?         |
| dS,<br>quires<br>en sign   | ed                                       |                                  |  |                                     |  |                  |                                   |                             |                        |                          |                          | 1 🗆                             | Yes 2                     | X No 3                     | Proba                   | ably 4 🗆                 | Unknown        |
| aw rec   | plet                                     |                                  |  |                                     |  |                  |                                   |                             |                        |                          |                          | 24a. Was                        |                           | 24b. W                     | ere autops              | sy findings              | available      |
| <b>Be</b> The la   | S  |                                  |  |                                     |  |                  |                                   |                             |                        |                          |                          | perfo                           | rmed?                     | de<br>o 1                  | ath?  Yes 2             |                          |                |
| ician:<br>certifica<br>ector,  |  |                                  | 5. Was case referre examiner?  | <u>(</u> `                          | Hospital:                                  |                  |                                   |                             | 26. Pla                | ce of Deat               | h (Check                 | only one)                       | 7                         |                            |                         |                          |                |
| kysi his o   | 2  | 1 ∐ Yes 2<br>7. Manurer of Death | No<br>n  |                                     |  | ER/Outpatien     |                                   | c. Injury                   | 4 ∐ Nu                 |                          | ne 5  Resid              |                                 |                           |                            |                         |                          |                |
| ivision of or Attending P after death. Director: After to in by the funers. Certificate: |  |                                  | 1 Natural<br>2 Accident  | 5 Pending                           | (Month,                                    | Day, Year)       | injury                            | м 2                         | work?                  | Yes 2 🗌                  | - 1                      | od. Describe i                  | iow injur                 | y occurred                 |                         |                          |                |
| ivision or Attendi after death. Director: A  | ertif                                    |                                  | 3 ☐ Suicide<br>4 ☐ Homicide  | 6 Could not determined              | 28e. Place of                              | f Injury - At ho | ome, farm, stre                   | et, factory,                | office                 |                          | 2                        | 8f. Location (S                 |                           |                            | or Rural F              | Route Num                | ber,           |
| Div<br>ital or<br>ital or<br>ral Dir   | 0  |                                  |  | <del></del>                         |  |                  |                                   |                             |                        |                          |                          | City or Tow                     |                           |                            |                         |                          |                |
| To the Hospital within 24 hours To the Funeral completely filled                         | Medical                                  | 2                                | (Check 2   | Medical Exar                        | ysician: To the bes<br>niner: On the basis | of examination   | n and/or investi                  | gation, in m                | y opinior              | n, death oc              | curred at 1              | he time, date a                 | ind place                 | and due t                  | o the caus              | e(s) and ma              | anner stated   |
| o the  | Σ  |                                  | only one) 3  |                                     | rse Practitioner: T                        | o the best of r  | ny knowledge,                     |                             | red at th<br>License   |                          | e and plac               | e, and due to t                 |                           | e(s) and ma<br>te signed ( |                         |                          |                |
| F > F 0  |  |                                  | ♠ (?).   | well-                               | TM.D                                       |                  |                                   |                             |                        |                          | 46                       |                                 |                           | 5/4                        | 1                       | 012                      |                |
|  | ,  | 3                                | 0 Name and addre   | ess of person who                   | completed cause                            | of death (Item   | 1 23a) (Type, Pi                  | rint)                       | ~ ,                    |                          | . 4                      | 0210                            | 11                        | 11                         | 10                      |                          |                |
| 4  |  |                                  | Patricia   | Gao. 2                              | /  | Hal D            |                                   | Slen                        | Bur                    | nil                      | WI                       | 1)210                           | 61                        |                            |                         |                          |                |
|  | State                                    | 3                                | 1. Date filed (Month   |                                     | 32. Reg                                    | istrar's Signat  | ure                               |                             |                        |                          |                          |                                 |                           |                            |                         |                          |                |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per INF G941 7/17/2013 JH. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Anita Belle Seymore May 05 5:35 PM Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Months 09/03/1939 Min Director 213-36-8230 1 M 2 X F 72 Usual Residence of Decede Maryland 28a-f show ms 23a or 28a-f sho must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3502 Thomas Pointe Court, Unit 1D 21009 U.S.A. items ? and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Homemaker Own Home Important: If item 27 is marked other any injury or other traumatic event, th once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hodges Elmer Lee Sherman Frances Amole 2012 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Seymore, Sr., / Husband 3502 Thomas Pointe Court, Unit 1D, Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 105/07/2012 Hanover, Maryland 21. Signature Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1. Enter the disease nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) LUNG CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine Diverto (unas a cur sectiones of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-trai Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Hospital or Attending Physician: The law requires that the death Month Day Year 1 Yes 2 9 Unknown 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be peen certificate has filled in by the funeral director, Be

Division of Vital Records, P.O. Box 68760 ANITA SEYMORE

|                                 |                           |   |  |                     |        |   |       | 1 L Yes 2 L No 3 L Probably 4 L Unknown   |  |  |  |  |
|---------------------------------|---------------------------|---|--|---------------------|--------|---|-------|---|--|--|--|--|
|                                 |                           |   |  |                     |        |   |       | 24a. Was an<br>autopsy<br>performed?<br>1 ☐ Yes 2 <b>X</b> No                   | 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No |  |  |  |
| 25. Was case referred examiner? | to medical                |   | 26. Place of Death (Check only one)  |                     |        |   |       |   |  |  |  |  |
| 1 ☐ Yes 2 X No                  |                           | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home |  |                     |        |   |       | ome 5 Residence 6 X Other (Specify) HOSPICE                                     |  |  |  |  |
| 2 Accident                      | 5 Pending Investigatio    | n (M  | ate of injury<br>Ionth, Day, Year)   | 28b. Time of injury | М      | 28c. Injury at<br>work?<br>1 ☐ Yes 2 ☐ No | 28d   | . Describe how injury   | occurred   |  |  |  |
|                                 | 6 Could not be determined | 28e. Pla  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |                     |        |   |       | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |  |  |  |  |
| 29a. Certifier 1                | Certifying Phy            | sician: To th   | e best of my knowl   | edge, death oc      | curred | at the time, date and place,              | and c | due to the cause(s) an  | d manner as stated.  |  |  |  |

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 5 1

of death (Item 23a) (Type, Print)

TRACIE L. MORGAN, 2300 DULANEY VALLEY RD. CRNP TIMONIUM. MD 21093 31. Date filed (Month, Day, Year,

State Registrar

မ

Certificate:

Medical

MAY 0 9 2012

After this

24 hours after deat Funeral Director:

the within To the

2

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                     |   |                  | For   | State of Ma  | aryland / Dep           | artment o  | of Health ar             | nd Mental Hy                                 | ygiene                         |   |   |     |
|---------------------|---|------------------|---|--|-------------------------|--|--------------------------|--|--------------------------------|---|---|-----|
|                     |   |                  | 1 - State Registrar Certificate of Death Reg. No. 2                                 |  |                         |  |                          |  |                                |   | 1471                                    |     |
|                     | Physicia  | an/              | Decedent's Name (First, Middle, La  | ,  |                         |  |                          | 2. Date of De<br>Month                       | eath<br>Day                    | Year                                      | 3. Time of Death                        |     |
| J.                  | Medi  | _                | Freda Marie  4a. Facility Name (if not institution, giv                             | Schneider  |                         |  |                          | May  | 04,                            | 2012                                      | 9:30 P                                  | VI  |
|                     | Exami   | ner              |   | ,  |                         |  | n, or Location of        | Death  |                                | ty of Death                               |   |     |
|                     | Funeral   |                  | Stella Maris Hos  5. Social Security Number 6.                                      |  | (In yrs. last birthday) | Timo   | ear If Under 24          |  | irth                           | altimo<br>9. Birthpl                      | ace (State or Foreig                    | an  |
| - 1                 | Director  |                  | 220-94-2301   | 1 □ M 2 🕱 F  | Yrs.                    | Months Da  | ays Hours                | Min. (Month, D                               |                                | Counti                                    | y)                                      |     |
| 100                 | ld<br>Now   | ] _              | Usual Residence of Decedent  10a, State 10b, County                                 |  | 10c. City, Town or L    |  |                          | 10/14  | /1965                          |   | y land  d. Inside City Limits           | _   |
|                     | arylar<br>a-f st<br>fied a  | Sc               | MD Baltin   | more   |                         | Jeation  |                          |  |                                | 10  | a. Inside City Limits                   |     |
|                     | the Mison 28  | <u>F</u>         | 10e. Street and Number  | liote  | Dundalk                 | 10f. Zip Co  | de                       |  | 10g. Citizen o                 | f What Count                              |   | -   |
|                     | with t  | eral             | 1903 Searles Roa  | ье   |                         | 212  |                          |  | U.S.A                          |   | у,                                      |     |
|                     | death<br>items<br>ier m   | Funeral Director | 11. Marital Status  | 12. Was Decedent Ev<br>Armed Forces?                   | ver in U.S. 13.         | Was Decedent   | of Hispanic Origin       | n? (Specify Yes or No<br>Puerto Rican, etc.) | - 14. Ra                       | ace - America                             |   |     |
| 9                   | after after camir   | ğ                | 1 Never Married 2 Married   | 1  Yes 2 X   | No .                    | 1 Yes 2  |                          | ruerto Rican, etc.)                          |                                | ack, White, et                            | C.                                      |     |
| 2                   | ours atura  | etec             | 3 Widowed 4 X Divorced  15. Decedent's  | Year or Dates.   |                         |  |                          |  | Specif                         | WD1                                       | • | _   |
| E .                 | 72 h<br>an "n<br>Medi   | Completed by     | (Specify only highest g   | rade completed)  | (Give                   | edent's Usual Oc<br>kind of work do<br>DO NOT use reti | one during most of       | f working                                    | 16b. Kind of                   | Business/Ind                              | ustry                                   |     |
| <u>a</u> 5          | withiir<br>giene<br>ger th  |                  | 12  | College (1-4 or 5-                                     |                         | oor Ins  | taller                   |  | Home 1                         | Improv                                    | ement                                   |     |
| :30                 | e filed<br>tal Hy<br>sd oth   | To Be            | 17. Father's Name (First, Middle, Last)   |  |                         |  | 18. Mother's             | s Name (First, Middle                        | , Maiden Surnar                | ne)                                       |   |     |
| 12 9:30 р.ш.        | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  | -                |   |  | Jr.                     |  | Joy                      | Freda  | Dixon                          |   |   |     |
| 12                  | 2 sho<br>th and<br>7 is r   |                  | 19a. Informant's Name/Relationship (  | ,, ,   |                         |  |                          | or Rural Route Number                        |                                |   | ode)                                    |     |
| 201                 | and<br>Healt<br>tem 2   |                  | Stephanie Ruscit 20a. Method of Disposition   | to / Sister  | 20b. Place of Disp      |  |                          | Dundalk, I                                   | MD 2122.                       |   | vn. Ctoto                               |     |
| IAY 4, 20           | age 1<br>ent of<br>nt: If i   |                  | 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec                                     |  |                         | matory or other  | place)                   | /07/2012                                     | Hanove                         | ,   |   |     |
| Y Z                 | mit. F<br>partm<br>portal<br>r injui  |                  | 21. Signature Ineral Service Lie  |  |                         |  | ddress of Facility       | Anatomy                                      |                                |   |   | _   |
| MAY                 | permii<br>Depar<br>Impor<br>any in  |                  | 1 BOK   |  | 4                       |  |                          | r., Ste. 1                                   |                                |   |   |     |
|                     |   |                  | 23a. Part 1. Enter the disease, or con shock, or heart failure. List only           | nplications that caused to one cause on each line.     | the death. Do not en    | er the mode of   | dying, such as car       | rdiac or respiratory a                       | rrest,                         |   | Approximate nterval Between             |     |
| 7                   | Physician/  | 0.0              | Immediate Cause (Final disease or condition   | LIVER DI   | SEASE                   |  |                          |  |                                |   | Onset and Death                         |     |
|                     | Medical<br>Examiner   |                  | resulting in death)   |  | consequence of):        |  |                          |  |                                |   |   |     |
|                     |   | ē                | Sequentially list conditions, if any, leading to immediate                          | b. Due to (or se a                                     | consequence of):        |  |                          |  |                                |   |   |     |
|                     | ted<br>Insit  | Examiner         | Cause, Enter Underlying Cause (bisease or injury                                    | Due to (or as a  | consequence or,         |  |                          |  |                                | -   |   |     |
|                     | execur<br>in and<br>ial-tra   | Ä                | that initiated events c.  resulting in death) Last Due to (or as a consequence of): |  |                         |  |                          |  |                                |   |   | _   |
| 09                  | ate be executed bhysician and the burial-transit  | dical            |   | d  |                         |  |                          |  | _                              |   |   |     |
|                     | tificat<br>ng ph  | Mec              | IF FEMALE:  |  |                         |  |                          |  |                                |   |   |     |
| Bov 687             | eath certifical<br>attending ph   | ian/             | 23b. Was decedent pregnant in the past 12 months?                                   |  | Fetal death 3           |  |                          |  |                                | ate of deliver                            |   |     |
|                     | the a   | Physician/Me     | 1 Yes 2 X No<br>9 Unknown   | 4 ☐ Pregnant at 9 ☐ Unknown                            | time of death 5 l       | Other (specify   | 1)                       |  | IV.                            | onth [                                    | ay Year                                 |     |
| DER                 | requires that the despensions of the school | y P              | Part II. Other significant conditions   | contributing to death bu                               | t not resulting in the  | underlying cause                                       | e given in Part I.       | 23e. Did t                                   | tobacco use con                | tribute to the                            | cause of death?                         |     |
| SCHNEIDER           | uires t<br>n sign   | ed by            |   |  |                         |  |                          | _ 1 🗆  | Yes 2 No                       | 3 🗆 Proba                                 | bly 4 Oknow                             | 'n  |
| SCHNE[I]            | w req   | plet             |   |  |                         |  |                          | 24a, Was                                     |                                | Were autops                               | y findings available                    | ,   |
| SC                  | Attending Physician: The law requires that the death certificate be executed ar death certificate be executed ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit   | Completed        |   |  |                         |  |                          | auto   | psy<br>ormed?<br>2 <b>X</b> No | prior to com<br>death?<br>1 \square Yes 2 | oletion of cause of                     |     |
| FREDA<br>of Vital B | ysician: The lis certificate director, pag  | Be C             | 25. Was case referred to medical examiner?  |  |                         | 26   | 6. Place of Death (      |  | 2 21 140                       | i les 2                                   | NO                                      |     |
| F. 5                | hysic<br>this co  | 욘                | 1 Yes 2 X No  |  | nt 2 ER/Outpatie        | nt 3 ∐ DOA   | Other: 4 \(\sum \) Nursi | ng Home 5 🗆 Resi                             | dence 6 🗷 Oth                  | ner (Specify)                             | HOSPICE                                 |     |
|                     | ding Phys<br>h.<br>After this<br>funeral d  | Certificate:     | 27. Manner of Death  1   Natural 5 □ Pending  | 28a. Date of injury<br>(Month, Day,                    | Year) 28b. Time o       | V  | njury at<br>vork?        |  | how injury occur               | red                                       |   |     |
|                     | I or Attenc<br>after death<br>Director:   | l≝∣              | 2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not t                               | De Place of Injur                                      | y - At home, farm, str  |  | Yes 2 No                 |  | Street and Numb                | nor or Pumi D                             | auto Alumbay                            | _   |
| Division            | pital or Attending Ph<br>ours after death.<br>eral Director. After th<br>filled in by the funeral   |                  | 4 ☐ Homicide determined   | building, etc.   |                         | cet, ractory, one                                      | 06                       | City or Tov                                  |                                | per or Hurai H                            | oute Number,                            |     |
|                     | Hospital<br>24 hours a<br>Funeral (letely filled  | ledical          | 29a. Certifier 1 Certifying Phy (Check 2 Medical Exam                               | /sician: To the best of m                              | ny knowledge, death     | occurred at the  | time, date and pla       | ace, and due to the c                        | ause(s) and man                | ner as stated                             | • | _   |
|                     | To the Hospital or<br>within 24 hours afte<br>To the Funeral Dir<br>completely filled in  | Me               | only one) 3 X Certifying Nur 29b. Signature and title of certifier                  | niner: On the basis of exa<br>rse Practitioner: To the | best of my knowledge    | , death occurred                                       | at the time, date a      | ind place, and due to                        | the cause(s) and               | manner as sta                             | ted.                                    | ed. |
| 4                   | 5 2 5 3   |                  | NAME OF CONTINE   | MAN  | IP, NIP                 | 29c. Lice  | ense number              | 212  | 29d. Date signe                | ed (Month, Da                             | y, Year)                                |     |
|                     | •   |                  | 30. Name and address of person who  | completed cause of dea                                 | ath (Item 23a) (Type, I | Print)   |                          | 210  | 0/                             | ///                                       |   | _   |
|                     |   |                  | TRACIE L. MORGA   |  | 00 DULANE               | Y VALLE  | Y RD. T                  | IMONIUM, 1                                   | MD 21093                       | 3   |   |     |
|                     | Stat<br>Registra  | i.e              | 31. Date filed (Month, Day, Year)  MAY 0 9 2012                                     | 32. Registrar  | s Signature             |  |                          |  |                                |   |   |     |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#10e, 19b, perFH, G927, 5/15/2012, WS State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death May 7, 2012 Physician/ George Hamilton Suter, IV 8:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Gilchrist Hospice of Howard County 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year\_ If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Jul 19, 1943 Months Days Hours Min. 213-40-2376 MD 1 M 2 □ F Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director Examiner must be notified **Ellicott City** MD Howard 1 Yes 2 No 10e3Systtand Number
-207 Evergreen Way 5 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21042 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or i þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) **Business Owner** Restaurant traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 **Dorothy Louise Fischbach** George Hamilton Suter III 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <del>- 207</del> Evergreen Way Ellicott City, MD 21042 3207 Hildy Suter spouse 20a. Method of Disposition
1 

Burial 2 

Cremation 3 

Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Atlantic Crematory, LLC Date 20c. Location - City or Town, State Department of Important: If it any injury or o once. May 08, 2012 Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Ure of Funeral Service Light 1110053 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ptsysician/ PTEMBER 2011 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to minimize cause. Enter Underlying Physician/Medical Examiner Diss to (or as a consequence of) attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, CIRRHOSIS DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of RESTAL CANCER 24a, Was an page 2 s autopsy death? RADIATION PROCTITIS 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Priyanamin within 24 hours after death.

To the Funeral Director, After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 \[ \text{Yes} 2 \[ \text{No} \] (Month, Day, Year) injury 1 💢 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b, Signature and title of certifie D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 CEDAR LANE COLUMBIA, MB 21044 DOBERMAN, MD DANIEUE 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 904A Month Medical 4a. Facility Name (if not institution, give street and number. 4c. County of Death Examiner City, Town, or Location of Death h to more Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last 9. Birthplace (State or Foreign Hours Country 213-11-2767 Director 1 □ M 2 🛣 Yrs. 55 May 4, 1957 India Usual Residence of Deced or 28a-f show 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🗌 Yes 2 🕱 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe 23a Funeral **Examiner must** 20904 United States 13300 Banbury Place "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian, Armed Forces Black, White, etc. þ 1 Yes 2 XNo 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Year or Dates Asian Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, the Me Maryland State College (1-4 or 5+) Elementary/Secondary (0-12) Therapist Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည P. J. Thomas Judith Lilly (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trai once. 13300 Banbury Place, Silver Spring, Maryland 20904 Govindan Swaminathan/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery
Crematorium, Inc. May 10,2012 20a. Method of Disposition 20c. Location - City or Town, State Department of 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Signature of Funeral Service Lice Robert A. Adress of Facility Funeral Home/Bethesda-Chevy Chase, Inc. The J.Fh. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) seudomonal Troumonia Medical Due to (or as a consequence of) Examiner variable ommon Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 \( \sum \) Yes 2 \( \sum \) No 1 🔀 Natural injury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lag havan Date filed (Month, Day, State 0 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 2/9912 Frances Oechsle Sams 10:00 P M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Anne Arundel Ginger Cove Health Center Annapolis Social Security Numbe . Age (In yrs. last birthday) If Under 24 Hrs. If Under 1 Year Date of Birth 9. Birthplace (State or Foreign **Funeral** Countre 1 □ M 2\□ F Months Davs Hours (MO27:1887:1936 562-54-5808 76 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits notified at 10c. City, Town or Location Director Yes 2 🗆 No MD Annapolis Anne Arundel 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be i Funeral 9202 River Crescent Drive 21401 USA Page 1 and 2 should be filed within 72 hours after death w ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or items; ury or other traumatic event, the Medical Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Travel Agent Travel Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ٥ Juan Oechsle Ruth Sigg 19b. Mailing Ad**hers** (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1605 Old <del>Main</del> Bottom Run, Annapolis, MD 21409 19a, Informant's Name/Relationship (Type, Print) Marian Sams Crane / Daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or or Chesapeake Crematory 5/5/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence oi). Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death ☐ Pregnant ☐ Unknown signed by the a 1 L Yes 2 L Part II. Other significant conditions contributing to death but not result 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Unknown should . Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy 1 Yes 2 this certificate 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Checar nly one) 2 1 Yes 2 DNo 1 Inpatient 2 I ER/Outpatient 3 I DOA ng Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 🔲 Yes 28b. Time of Certificate: 28d. Describe how injury occurred After iniury Natural 5 Pending 2 🗌 No Accident Investigation after death Director; / Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of cep 29d. Date signed (Month. Dav. Year) 2 30. Name and address of pe ompleted ca 6 OV State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 14720 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **07**<sup>Day</sup> Donald Leroy Smith, Sr. 2012 May 9:30 A. M Medical Facility Name (if not institution, give street and number) **Examiner** or Location of Death nty of Death 2006 Stockton Road Baltimore County Phoenix Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 216-12-0676 1 **X**M 2 □ F 88 Aug. 04, 1923 Seattle, Washington **Director** Usual Residence of Decedent 28a-f show at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Baltimore County Phoenix 1 Yes 2 XNo 10e. Street and Number Ö 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 2006 Stockton Road 21131 United States items 12. Was Decedent Ever in U.S.
Armed Forces? Army
1 4 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Year or Dates. W.W.II White 3 Widowed 4 Divorced Specify Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) 12 College (1-4 or 5+) **N/A** the Electrician Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever Edward R. Smith Mary L. Aubaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trauonce, Phoenix, Maryland Mr.Donald Leroy Smith,Jr.(Son) 2006 Stockton Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Moreland Memorial Park May 11,2012Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service recense Jeffrey L.Gair, Sr. OFP 2. Name and Address of Facility Reactives Funeral and Cremation Center, P.A.

1. Cair, Sr. OFP 2. Name and Address of Facility Reactives Funeral and Cremation Center, P.A.

1. Cair, Sr. OFP 2. Name and Address of Facility Reactives Funeral and Cremation Center, P.A.

1. Cair, Sr. OFP 2. Name and Address of Facility Reactives Funeral and Cremation Center, P.A.

1. Cair, Sr. OFP 2. Name and Address of Facility Reactives Funeral and Cremation Center, P.A.

1. Cair, Sr. OFP 2. Name and Address of Facility Reactives Funeral and Cremation Center, P.A.

1. Cair, Sr. OFP 2. Name and Address of Facility Reactives Funeral and Cremation Center, P.A.

1. Cair, Sr. OFP 2. Name and Address of Facility Reactives Funeral and Cremation Center, P.A.

1. Cair, Sr. OFP 2. Name and Address of Facility Reactives Funeral and Cremation Center, P.A.

1. Cair, Sr. OFP 2. Name and Address of Facility Reactives Funeral and Cremation Center, P.A.

1. Cair, Sr. OFP 2. Name and Address of Facility Reactives Funeral and Cremation Center, P.A.

1. Cair, Sr. OFP 2. Name and Address of Facility Reactives Funeral and Cremation Center, P.A.

1. Cair, Sr. OFP 2. Name and Address of Facility Reactives Funeral and Cremation Center, P.A.

1. Cair, Sr. OFP 2. Name and Address of Facility Reactives Funeral and Crematic Reactives Funeral Address of Facility Reactives Funeral Address Funeral Address of Facility Reactives Funeral Address of Facility Reactives Funeral Address Fu 2325 York Road Timonium, Maryland 21093-2215 . Pay 1. Enter the disease, or go shock, or heart failure. List only plications that Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Ph si ian disease or condition Medical resulting in death) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No be detached g Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 20 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe After this certificate 1 Yes 2 Vid 1 Yes 2 No filled in by the funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: Residence 6 Other (Specify, မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural Accident 5 Pending injury s after death. Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4  $\square$  Homicide determined City or Town, State) within 24 hours a To the Funeral I To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature

Registrar

DHMH 17 Rev 06-2011

State

and addres

31. Date filed (Month, Day, Year)

4082

(Item 23a) (Type, Print)

MANORE

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Mdh. For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4, 10 Physician/ 2012 6:54pm ODELL SANDERS 90 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death TOWSON BALTIMORE 12 AIRWAY CIRCLE APT 2A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 2015 **Funeral** Days Hours Min 428-88-5576 1 🛚 M 2 🗆 F **Director** 2-27-1946 MISSISSIPPI 66 Usual Residence of Decedent 28a-f shov 10a. State 100 aţ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 X Yes 2 □ No BALTIMORE TOWSON MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 05 the Medical Examiner must be 23a Funeral 12 AIRWAY CIRCLE APT 2A 21286 USA items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Deceden. \_\_\_\_\_ Armed Forces? 1 ☐ Yes 2 🔀 No Sanders Black, White, etc. and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: BLACK Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) WELDER GENERAL MOTORS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ R.J. SANDERS NADIE DIXON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau J.W. SANDERS (BROTHER) 6412 JONAS WAY GWYNN OAK, MARYLAND 21207 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) tion 3 Removal from State 4 Donation 5 D Other (Specify) METRO CREMATORY 5-8-2012 BALTIMORE, MARYLAND HIBNER<sup>2</sup>. Name and Address of Facility icensee JOHATHAN REDD FUNERAL SERVICE. MONROE ST. BALTIMORE, MARYLAND Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Arterioge Onset and Death Immediate cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ☐ Live Birth 2 ☐ Fetal God ☐ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I by Records, 1 Yes 2 No 3 Probably 4 Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I performed certificate 2 No 1 Ves **Division of Vital** 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\nearrow$  Residence 6  $\square$  Other (Specify) Hospital 1 X Yes 2 🗌 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural injury 5 Pending work?
1 Yes 2 No n 24 hours after death.

Funeral Director: A pletely filled in by the fi Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one within To the 29b. Signatur 29d. Date signed (Month. Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ī rivu Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 19a per fh g927 5-9-12 vt
State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month 2012 Physician/ ern 1/ex (re Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner N/A 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days Min. Months 101-40-8542 1 □ M 2 🛚 F Director 07/29/1952 NY 59 Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f sho Director 1 X Yes 2 ☐ No BALTIMORE N/AMD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Completed by Funeral 21218 3704 N. CHARLES STREET, #501 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No . Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 🗆 Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify. Specify: WHITE If Yes, Give Year or Dates. 3 Widowed 4 Divorced th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) NON-PROFIT ADMINISTRATIVE DIRECTOR Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည **GELLER** HENENFELD ZEENA ROBERT 19a Informant's Name/Relationship (Type, Print)

Barney Joel Stern

BARNE: STERN / HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3704 N. CHARLES ST., #501, BALTIMORE, MD 21218 other 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place)
GARRISON FOREST OF
HIZUK AMUNO CONG. Department of Important: If it ö 1 X Burial 2 Cremation 3 Removal from State 05/06/2012 OWINGS MILLS, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mars 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) OVARIAN METASTATIC Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 Yes 2 V 9 Unknown ed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy funeral director, page 2 1 Yes 2 No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred after death. Director: After 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident by the f Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined filled in To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier + 2012 MAY RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Orleans

COOPER

MICHOL COON
31. Date filed (Mornth, Day, ¥ear)

1800

St.

Balhmore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SYLVIA SHAPIRO Mai Zilo A M Medical 2012 4a. Facility Name (if not institution, give street and number, Examiner 4b. City. Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltimore N/ASocial Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 219-18-6556 Director 1  $\square$  M 2 X F 88 03/24/1924 MD 10a. State 10b County 10c. City, Town or Location notified at Director 10d. Inside City Limits 28a-f MD BALTIMORE PIKESVILLE 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 7920 SCOTTS LEVEL ROAD 21208 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black White etc. 9 ş 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 □ Divorced Specify Year or Dates WHITE Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene Important: If item 27 is marked other this any injury or other traumatic event, the once. CLAIMS EXAMINER FEDERAL GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ NATHAN GOLDBERG LENA **KESSLER** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANIS STEVENS/DAUGHTER 3613 CHESTNUT AVENUE, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) BETH JACOB CEMETERY 05/07/2012 FINKSBURG, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mark 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician. Myocardial infarction disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🔀 No Dav Yes the 9 Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by fibrilation 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available has page 2 prior to completion of cause of death?

1 Yes 2 No autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Yes 잍 hospic e 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural Accident 5 Pending after death.

Director: Af 1 Yes 2 No the Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) completely filled in by 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one Certifying Nurse Practitioner: To the bank of my knowledge 29b. Signature a 29d. Date signed (Month, Day, Year) WD20/2 30. Name and dress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

Guazhon

31. Date filed (Month, Day, Year)

240

W Belveolere Ave, Balti more MD 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DITH SHAPIRO 3:35 P M MA 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MILFORP MANOR BALTIMORE PIKESVILLE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days **Director** 220-07-8662 1 M 2 X F 93 01/25/1919 MD Usual Residence of Deced 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🛚 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8804 HOWARD FOREST LANE 21208 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 □ Divorced Specify: Completed WHITE Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) OWNER RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 MORRIS G ROSENFELD MINNIE l and 2 should b i Health and Mer tem 27 is mark GINSBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEROME SHAPIRO / BROTHER-IN-LAW 8804 HOWARD FOREST LANE, BALTIMORE, MD 21208 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW 05/08/2012 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS..INC. Mats 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Phylician END STAGE DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No for Pregnant at time of death detached the 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signer should be c 1 Yes 2 No 3 Probably 4 Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform 1 Yes 1 Yes 2 🕨 or Attending Physician: 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? 12 2 🖳 No 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No nours after death.

neral Director: Af

filled in by the fu 2 Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title 29d. Date signed (Month, Day, Year) DS7722 M.D. 2012

DHMH 17 Rev 06-2011

State

Registrar

LEONARD

31. Date filed (Month, Day, Year)

9 2012

1838 GREENE TREE ROAD #300.

PIKESVILLE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

RICH ARDSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 05<sup>Day</sup> Month MAY 2012 NANCY SCHWARTZ 10:38A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE POWERBACK REHABILITATION LUTHERVILLE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 □ M 2 🗓 F Min Days Hours 57 Yrs. 66*7,28/1*954 219-68-7953 Director Usual Residence of Decedent 28a-f show ms 23a or 28a-f shorms must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 X Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6504 TROTWOOD COURT 21209 items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ò ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 'natural", Completed Specify: 3 Divorced 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Give kind of work done life. DO NOT use retired) CUSTOMER than College (1-4 or 5+) Elementary/Seconday (0-12) SERVICE REPRESENTATIVE CUSTOMER SERVICE is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ELLIOTT ROSENBERG PHYLLIS BERMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, JAMES SCHWARTZ / HUSBAND 6504 TROTWOOD COURT, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1  ${f \widetilde{M}}$  Burial 2  ${f \Box}$  Cremation 3  ${f \Box}$  Removal from State cemetery, crematory or other place) ANSHE EMUNAH AITZ CHAIM 4 ☐ Donation 5 ☐ Other (Specify) 05/07/2012 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition CARDIAC ARREST Medical resulting in death) Due to (or as a consequence of) Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury VASCULITIS burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as the s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ò Pregnant at time of death 5 Other (specify) Month Day Year been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 24 No Be 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Other:
4 
Nursing Home 5 
REHABILIT
Residence 6 
Other (Specify) 1 ☐ Yes 2 🗓 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident
Suicide Investigation s after death by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after
To the Funeral Direcompleted filled in b City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) 2

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 14726 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $M_{\text{ay}}^{\text{Month}}5$ ,  $201^{\circ}2$ Physician/ 11:00 а м Sherer Shirley Janet Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 83 060-22-7134 1 🗆 M 2 🍱 F Director 12/6/1928 New York Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 1 Yes 2 No Pasadena MD Anne Arundel 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral USA 21122 673 Riverside Dr. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Completed ntal Hygiene. ed other than "nature event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) March of Dimes Administrative Assistant Be Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Oberle John L. Johnson Louise Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 673 Riverside Dr., Pasadena, MD 21122 Melinda L. Tewell (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Lorraine Park Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/11/12 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final nset and Deat Physician/ Uneumonia weelh disease or condition Medical resulting in death) **Examiner** candida intection Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal dear Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s performed 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဝ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amapalis MD 21401 445 Hishway Detense

DHMH 17 Hey 06 2011

State Registrar gistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last, Time of Death 2. Date of Death Physician/ Worth > RIOLO 20 Medical Jown, or Location of Death 4a. Facility Name (if not institution, give street and number Examiner 4c. County of Death 4 MORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 220-80-6312 **Director** 1 🗆 M 2 🗶 F 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** be notified 1X Yes 2 No MARYLAND Merc 0 10e. Street and Number 10g. Citizen of What Country ms 23a c must be 21224 2 items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 0 ģ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Unite "natural" Completed 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. QO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 77 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. OWN HOME tomemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည e OLN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur Route Number, City or Town, State, Zip Code) 27 item 2 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 Department of Important: If it any injury or o once. ō Burial 2 ☐ Cremation 3 ☐ Removal from State 5-12-2012 Donation 5 Other (Specify) osuph of Juneral Service Licenses 21. Signature 23a. Part 1. Enter th shock, or heart complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Dea Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death detached the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform 2 No 1 Yes Yes funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient ☐ ER/Outpatient 3 ☐ 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 2 Accident injury work? 5 Pending filled in by the Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signatu 2012 pleted cause of death (Item 23a) (Type person who co BACTIAINE 21201

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14728 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $M_{ay}^{\text{Month}}$ Physician/  $2012^{\text{Year}}$ Patsy Ruth Tokarski 3 3:05p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4505 Cherry Tree Lane Sykesville Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 04/25/1934 226-38-5744 West Virginia Director 1 □ M 2 🗓 F 78 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Md Carroll Sykesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code ms 23a or must be r ö 10g. Citizen of What Country? Funeral 21784 USA 4505 Cherry Tree Lane er than "natural", or items the Medical Examiner mu be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Specify: White "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) 10yrs College (1-4 or 5+) Carroll Hospital Dietary Aid Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Washington White Lilly Abshire Legartment of Health ar.
Important: If item 27 is any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty J. Garland (Daughter) 4505 Cherry Tree Lane Sykesville, Md. 21784. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burlal 2 Cremation 3 Removal from State 05/07/2012 Eldersburg, Md. Lake View 4 Donation 5 Other (Specify) 21. Signature of Funeral Septice Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Pa. P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical consequence of) **Examiner** 05 Sequentially list conditions if any, leading to immediate to or as a consequence of): -transit Cause (Disease or injury 120 and that initiated events resulting in death) Last physician ar Physician/Medical CMS To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: for use yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 month Pregnant at time of death Month Day Year is been signed by the 2 should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tob cco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy performed 1 Yes Yes/2 25. Was case referred to dedical Be 26. Place of Death (Check only one, examiner? ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License numbe 29d. Date signed (Month. Day, Year) 016206 2012 who completed cause of death (fam 23a) (Type, Print) 10V E. YAL 31. Date filed (Month State

Registrar

12-03430 Cheryl Thomas

Mе

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 14729

|  |                | 1- For State<br>Registrar  | Certifica   | te of Death                  |  | Reg                              | . No.                          |   |
|--|----------------|--|---|------------------------------|--|----------------------------------|--------------------------------|---|
| Physici  | an/            | 1. Decadent's Name (First, Middle,Las  | )   | ·                            |  | Date of Death     Month          | Day Year                       | 3. Time of Death<br>1740 hrs              |
| dical Exami  | ner            | Lhery 1  | nomas   | All City Town                | and postion of Dooth                   | May 3, 2012                      | 4c. County of Death            |   |
|  |                | 4a. Facility Name (if not institution, given 428 Cummings Court              | street and number)  | Baltimore                    | or Location of Death                   |                                  | 4c. County of Death            |   |
| Funeral  |                | 5. Social Security Number 6. Se  | 7. Age (In yrs. last birth                                    |                              |  | _ , ,                            | (MM/DD/YYYY) 9. Bird<br>Foreig |   |
| Director   |                | 215-74-3489  | M 2VF 44  | Yrs. Months D                | Days Hours Min.                        | 03/23                            |                                | untry) MD                                 |
| any  |                | Usual Residence of Decedent  10a, State 10b. County                          | 10c. City, Town o   | or Location                  |  |                                  |                                | 10d. Inside City Limits                   |
| <b>E</b> .,  | _              | MD   | Balt  | move                         |  |                                  |                                | 1 Yes 2 No                                |
| hours after death with the Maryland<br>'natural', or items 23a or 28a-f show<br>Examiner must be notified at once,   | Director       | 10e. Street and Number   | Λ   | 10f. Zip Cod                 | 1201                                   | 100                              | Citizen of What Coul           | ntry?                                     |
| vith the s 23a o   |                | 428 Cummina  | 12. Was Decedent Ever in U.S.                                 | 13. Was Decedent of          |  | pecify Yes or No-                | 0.0                            | ican Indian, Black,                       |
| death v<br>or item<br>must b   | Funeral        | 1 Never Married 2 Married  | 1 Yes 2 ✔ No  |                              | ban, Mexican, Puerto                   | Rican, etc.)                     | White, etc.                    | act                                       |
| after after iner   | ğ              | 3 Widowed 4 Divorced   | or Dates:   | 1 Yes 2 🗹                    | No specify:<br>upation (Give kind of v | vork done                        | Specify: DI                    | Industry 4                                |
| 72 hours afte<br>"natural",  | eted           | Elementary/Secondary (0-12)  | College (1-4 or 5+)   | furing most of working       | life, DO NOT use reti                  | red)                             | baltimo                        | re City                                   |
| 215-0036 be filed within 72 hours ntal Hygiene. rked other than "natur ent, the Medical Exam   | Completed      | 12th   |   | <u> intenanc</u>             |  | nne                              |                                | ansportation                              |
|  | Be Co          | 17. Father's Name (First, Middle, Last)                                      | mas   |                              | 16. Namer's Name                       | . V.                             | nden surname)                  |   |
| 2 B & B &  | To B           | 19a Informant's Name/Relationship (T   |   | . Mailing Address (S         | treet and Number on                    |                                  | er, City or Town, State        | e, Zip Code)                              |
| and 2 sho (ealth and tem 27 is traumati  | [              | James Thomas   | (Uncle) 8   | 211 Char                     | dler Cou                               | rt, 上川i                          | 20c. Location - City or        | MD 21043                                  |
| ages I an nt of Hea  |                | 20a. Method of Disposition  1 Burial 2 Cremation 3                           | Removal from State  | ory or other place)          | r carnetery,                           | Date<br>山山つ                      | Minden                         | Will MD                                   |
|  |                | 4 Donation 5 Other Specify  2(1. Signature of Funeral Service Lice           |   | 22. Name and Act             | ress of Pacility                       | ene fu                           | nem S                          | errices                                   |
| Balti<br>permit.<br>Departm<br>Imports   |                | Vaughn C.  | heere   | 5151 3                       | utto Na                                | t'i PiK                          | e (21229                       |   |
| Physician  |                | 23a. Part I. Anter the disease, or comp<br>failure. List only one cause on e | plications that caused the death. Do no ach line.             | t enter the mode of dy       | ing, such as cardiac o                 | or respiratory arres             | st, shock, or heart            | Approximate Interval<br>Between Onset and |
| /Medical<br>≟xaminer   |                | Immediate Cause (Final disease a. or condition resulting in death)           | Asphyxia  Due to (or as a consequence of):                    |                              |  |                                  |                                | Death                                     |
|  |                |  | Strangulation   |                              |  |                                  |                                |   |
|  | ner            | if any, leading to immediate cause. Enter Underlying Cause                   | Due to (or as a consequence of):                              |                              |  |                                  |                                |   |
| X =  | Examine        | (Disease or injury that initiated events resulting in death) Lest            | Due to (or as a consequence of):                              |                              |  |                                  |                                |   |
| 760, cate be executed physician and the burial - transi  | Cal            | UNPENDED d   | AMENDED   |                              |  |                                  |                                |   |
| 760, icate be physiciate buria   | Medical        | IF FEMALE:   | 23c. If yes, outcome of pregnancy                             |                              |  |                                  | 23d. Date of deliver           |   |
|  | ian/           |  | 1 Live birth 2  | Fetal death  Other (Specify) | 3 Ectopic pregn                        | ancy                             | Month                          | Day Year                                  |
| Box 68: death certif the attending   | Physician      | 1 Yes 2 No 9 ✔ Unknow  |   | Other (Specify)              |  |                                  |                                |   |
| P.O. Be<br>that the des<br>med by the a  |                |  | contributing to death but not resulting                       | g in the underlying cau      | use given in Part I.                   |                                  | pacco use contribute to        | the cause of death?                       |
| Juires t<br>quires t<br>an sign<br>ald be c  | led t          |  |   |                              |  | 24a. Was a                       |                                | utopsy findings available                 |
| cord<br>law rec<br>has bee<br>2 shou   | Completed      |  |   |                              |  | autops<br>perform                | ned? death?                    | completion of cause of                    |
| Re(<br>The ficate  | 5              | 25 111   |   | 26.6                         | Place of Death (Check                  | 1 Yes 2                          | 2 No 1 <b>✓</b> Y              | es 2 No                                   |
| lital<br>sician<br>is certi  | 8              | examiner?  | Hospital: 1 Inpatient 2 ER/O                                  | utpatient 3 DOA              | TOther .                               |                                  | Residence 6 🗹 Othe             | er: Scene                                 |
| of Vital Records, P.C.  Jing Physician: The law requires that  After this certificate has been signed funeral director, page 2 should be dete  | 1.7            | 27 Manner of Death   | 28a. Date of Injury 28b.                                      |                              | Injury at Work?                        | 28d. Describe h<br>Subject strai | ow injury occurred             |   |
| ion<br>ttendir<br>leath.<br>tor: A   | atio           | 1 Natural 5 Pending 2 Accident Investiga                                     | tion May 3, 2012 1728   | 8 hrs                        | Yes 2 ✔ No                             |                                  |                                |   |
| Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rast after death.  **ID Invector: After this certificate has been signed by lied in by the funeral director, page 2 should be deated led in by the funeral director, page 2. | Certification: | 3 Suicide 6 Could no   |   |                              | ice building, etc.                     | or Town, St                      |                                | ural Route Number, City MD                |
| Hospi<br>24 hou<br>Funer   |                |  | clan: To the best of my knowledge, de                         | ath occurred at the tim      | ne, date and place, an                 | d due to the cause               | e(s) and manner as sta         | ited.                                     |
| To the within To the Comple  | Medical        | one) 2 Medical Examine 29b. Signature and title of certifier                 | er:Dn the basis of examination and/or i<br>and manner stated. |                              | inion, death occurred<br>cense number  | at the time, date a              | and place, and due to t        |   |
|  | ≥              | 29b. Signature and title or certifier  |   |                              | .C.M.E.                                |                                  | May 4, 2012                    | ,   |
| 6  |                | 30. Name and address of person who   | completed cause of death (Item 23a)                           |                              | <del></del>                            |                                  |                                |   |
| 5  |                | Donna M. Vincenti, MD  | Assistant Medical Examiner                                    | 900 W. Baltim                | ore Street, Balti                      | more, MD 21:                     | 223                            |   |
| Regi   |                | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signature                                     | 10                           |  |                                  |                                |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 201 Physician/ Tulskie Month 14:30 pm Hnna Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Howard Country General Hospital Columbia 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Hours Min (Month, Day Year) Nov 17, 1929 PA 182-24-2263 Director 1 - M 2 XF 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Examiner must be notified at Director PA Delaware Aston 1 Yes 2 No the or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 19014 702 Springton Circle U.S.A. or items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ρ 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 White 1 Tes 2 No Specify. Specify 27 is marked other than "natural", traumatic event, the Medical Exa 3 → Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **Administrative Assistant** Healthcare 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Elizabeth Revello **Dominic Masciantonio** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2877 Thornbrook Rd Ellicott City, MD 21042 19a. Informant's Name/Relationship (Type, Print) Hedwig T. Doherty daughter or other 20b. Place of Disposition (Name of cemetery, crematory or other place Holy Cross Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H
Important: If ite
any injury or otl
once. 1 Burial 2 Cremation ③ ☐ Removal from State May 07, 2012 Darby, PA Donation 5 Other (§ ecify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 ture of Muneral Servi untelle sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Meumoni Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month 1 Yes 2 No for Day Year 5 Other (specify) ed by the at detached fi 1 Yes 2 D Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 certificate has 2 🗆 No 1 Yes 24 hours after death.
Funeral Director: After this certifica etely filled in by the funeral director. To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 1 Natural 28d. Describe how injury occurred 5 Pendina 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Cartifying ordy one beath occurred at the time, date and place, and due to the cause(s) and manner as state within 2 To the I 29c. License number 29b, Signature and title of certified May 3rd 2012 00 B1 30. Name and address of person who completed cause of death (Item 23a) (Type, I S N 2000 K. Abdo 10910 Little fatuxent

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Towson Gilchrist Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** April 16, Days Hours 056-18-0742 Director 1 🗌 M 2 🕅 F 88 New York 1924 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct Maryland Baltimore Cockeysville 1 Yes 2 No 10f. Zip Code 21030 10e. Street and Number 10g. Citizen of What Country? United States 10012 Old Providence Way Apt. F Funeral of America 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 XXNo 1 Never Married 2 Married δ e filed within . \_\_ antal Hygiene. " ~ther than "natural", c Maryland 21215-0036 1 Yes 2 XNo Specify: white Specify: 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Handicapped (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Children should be filed with and Mental Hygien is marked other th Children's Attendant 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Joe Mavaro Annie Porcaro and 2 should be Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tuttie "Tony" Fusco/ son 15335 Old York Road Monkton, Maryland 21111 injury or other Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot May Date 20c. Location - City or Town, State St. Joseph Church 1XBurial 2 Cremation 3 Removal from State 2012 4 ☐ Donation 5 ☐ Other (Specify) Cockeysville, Maryland Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A.
2325 York Road Timonium, Maryland 21093 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1, Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RENEOF RIGHT FOOT disease or condition WOOK Medical resulting in death) Examiner IPHERAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sician and burial-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the human-town. Due to (or as a consequence of): resulting in death) Last Box 68760 く /Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death Physician/ 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) Day 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ RIGHT LOQ 1 🗆 Yes 2 🗹 No 3 🗆 Probably 4 🗆 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? DIABETES MELLI 24a, Was an PERTENSION performed 2 🗷 No Yes 2 No 1 Yes 25. Was ca referred to medical examiner?
1 ☑ Yes 2 ☐ No **Division of Vital** Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1+0.5PIC မူ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 3/23/2012 1 ☐ Yes 2 No Investigation unknown M 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) / 000 | 2 Ci V Pa villanco ROGO, Coc Key SUI'LLE, My determined tanne Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MAN Q 30. Name ar address of person who completed cau 31. Date filed (Month, Day, Year) State MAY 0 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Year Day 33 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 14 More If Under 1 Year | If Under 24 Hrs. **Funeral** Age (in vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Dec 10, 1963 Days 215-96-8318 48 MD **Director** shov 10c. City, Town or Location notified at Director 10d. Inside City Limits 1 Yes 2 No 28a-f **Baltimore City Baltimore** 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? be Funeral 23a 1301 Silverthorne Road 21239 U.S.A. must 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. þ 1 X Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 🗆 Yes 2 ื No Black Specify: Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the I Disabled Disabled 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည French Williams Bessie Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bessie Williams 1301 Silverthorne Road, Baltimore, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. 1 Burial 2 Cremation 3 Removal from State May 09, 2012 Pikesville, Maryland **Druid Ridge Cemetery** 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 Signature of Funeral Service License Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Iminant Medical **Examiner** omyory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the at d be detached fo g Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ည 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending (Month, Day, Year) 1 🔀 Natural 5 Pending 1 Yes M 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier RES-800 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, . ivatsan Kaghavan 860 eans St, Balhmore State Registrar

12-03460 Darian M. Wilder

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| 20 |  | 2 | 14 | 7 | 3 |  |
|----|--|---|----|---|---|--|
|----|--|---|----|---|---|--|

|  |   | 1- For State Certific   | cate of Death   | Reg. N                                   | Z U 1                            | L 1470  |  |  |  |  |  |
|--|---|---|---|--|----------------------------------|---|--|--|--|--|--|
| Physicia<br>edical Exami   | an/   | Decedent's Name (First, Middle,Last)  |   | 2. Date of Death<br>Month Da             | y Year                           | 3. Time of Death<br>1617 hrs                  |  |  |  |  |  |
| culcul Exami   | 1161  | DARIAN M. WILDER  4a. Facility Name (if not institution, give street and number)  | 4b. City, Town, or Location of Death  | May 4, 2012                              | 4c. County of Death              |   |  |  |  |  |  |
|  |   | 4000 Nicholson Street   | Hyattsville   |  | Prince George                    |   |  |  |  |  |  |
| Funeral<br>Director  |   | 5. Social Security Number 6. Sex 7. Age (In yrs. last b   | irthday) If Under 1 Year If Under 24Hrs.  Months Days Hours Min.  | 8. Date of Birth(M                       | M/DD/YYYY) 9. Birti<br>Foreigi   | place (State or PITTS. PA                     |  |  |  |  |  |
| Director   |   | 178-60-5048 1 1 M 2 F 33  Usual Residence of Decedent   | Yrs.  | DEC. 20                                  | 19/8 Co.                         | intry)  |  |  |  |  |  |
| any  |   | 10a. State 10b. County 10c. City, Tow   | n or Location   |  |                                  | 10d. Inside City Limits                       |  |  |  |  |  |
| and show   | ъ   | MD PRINCE GEORGE'S HYAT   | TSVILLE   |  |                                  | 1 X Yes 2 No                                  |  |  |  |  |  |
| ne Maryland<br>or 28a-f show any<br>ified at ooce.   | Director  | 10e. Street and Number  | 10f. Zip Code   | 10g. (                                   | Citizen of What Coun             | try?  |  |  |  |  |  |
| death with the Maryland<br>or items 23a or 28a-f sho<br>must be notified at ooce.  | a D   | 4000 NICHOLSON STREET  11. Marital Status  12. Was Decedent Ever in U.S.  | 20782  13. Was Decedent of Hispanic Origin? ( Sp  | US.                                      | A<br>14. Race - Americ           | an Indian Black                               |  |  |  |  |  |
| leath w  | Funeral   | 1 X Never Married 2 Married Armed Forces?   | If Yes, specify Cuban, Mexican, Puerto  |  | White, etc.                      | an indian, black,                             |  |  |  |  |  |
| after o  | by F  | 3 Widowed 4 Divorced If Yes, Give Year or Dates:  | 1 Yes 2 No specify:   |  | Specify: BL                      | ACK   |  |  |  |  |  |
| hours  | ted   | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)             | <ul> <li>Decedent's Usual Occupation (Give kind of w<br/>during most of working life, DO NOT use retir</li> </ul> |  | . Kind of Business/Ir            | dustry  |  |  |  |  |  |
| 336<br>thin 72<br>then<br>then<br>edical   | Completed   | 4YRS  | STUDENT   |  | PRIVATE                          |   |  |  |  |  |  |
| 5-0(<br>led wi<br>Hygier<br>other  |   | 17. Father's Nama (First, Middle, Last)   | 18.Mother's Name  | (First, Middle, Maide                    | en Surname)                      |   |  |  |  |  |  |
| 21215-0036 unid be filed within 7 Mental Hygiene. marked other than c event, the Medica  | o Be  | GEORGE R. LEWIS JR.  19a. Informant's Name/Relationship (Type, Print)   | 9b. Mailing Address (Street end Number or R   | WILDER                                   | City or Town State               | Zin Codo)                                     |  |  |  |  |  |
| AD 2 shou h and h and h 27 is n  | ۴   |   | 5009 40th PLACE #208  |  |                                  |   |  |  |  |  |  |
| Fe, Fe and F Healt   |   |   | of Disposition (Name of cemetery, atory or other place)   | Date 20                                  | c. Location - City or 1          | rown, State                                   |  |  |  |  |  |
| Pages ment of tants of oth   |   | 4 Donation 5 Other Specify: RIVE:   | RDALE CREMATORY 5/1   |  | IVERDALE,                        |   |  |  |  |  |  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "oatural", or items 23a or 28a-f sho injury or other traomatic eveet, the Medical Examiner must be notified at occe.            |   | 21. Signature of Funeral Service Licensee   | 22. Name and Address of Facility J. 7474 LANDOVER ROAD  |  |                                  |   |  |  |  |  |  |
| Physician  | $\dashv$  | 23a. Part I. Enter the disease, or complications that caused the reath. Do  |   |  |                                  | Approximate Interval                          |  |  |  |  |  |
| /Medical<br>Examiner   |   | failure. List only one cause on each line.  Immediate Cause (Final disease a, Brainstem Hemorrhage                            |   |  |                                  | Between Onset and<br>Death                    |  |  |  |  |  |
| Examiner   |   | or condition resulting in death)  Due to (or as a consequence of):  Hypertensive Cardinyascul                                 | ar Disease  |  |                                  |   |  |  |  |  |  |
|  | Je.   | Sequentially list conditions, if any, leading to immediate Cause, Enter I Inderlying Cause.  Due to (or as a consequence of): |   |  |                                  |   |  |  |  |  |  |
|  | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of): |   |   |  |                                  |   |  |  |  |  |  |
| 1760,<br>ficate be executed<br>g physician and<br>the burial - transit   |   | d   |   |  |                                  |   |  |  |  |  |  |
| '60,<br>rate be executed<br>obysician and<br>re burial - transi  | Medical   | UNPENDED AMENDED  |   |  |                                  |   |  |  |  |  |  |
| 1876<br>rtificate<br>ing phy<br>as the l   |   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnanc                                 | y<br>2 Fetal death 3 Ectopic pregnar  |  | 3d. Date of delivery<br>Month Da | ay Year                                       |  |  |  |  |  |
| Vital Records, P.O. Box 687 yaiciae: The law requires that the death certific his certificate has been signed by the attending p director, page 2 should be detached for use as the  | Physician/  | 1 Yes 2 No 9 Unknown 9 Unknown  | 5 Other (Specify)   |  |                                  |   |  |  |  |  |  |
| D. B. tribe de by the ached i  |   |   | ing in the underlying cause given in Part I.  | 23e. Did tobaco                          | o use contribute to the          | ne cause of death?                            |  |  |  |  |  |
| Division of Vital Records, P.O. all or Attending Physiciae: The law requires that the start death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach   | d by  | Obesity   |   | 1 Yes 2                                  | No 3 Proba                       | abiy 4 🗹 Unknown                              |  |  |  |  |  |
| ords<br>w requisite provided   | Completed   |   |   | 24a. Was an autopsy                      | prior to co                      | opsy findings available impletion of cause of |  |  |  |  |  |
| Rec<br>The la<br>icate ha  | E   |   |   | performed<br>1 Yes 2                     |                                  | 2 No  |  |  |  |  |  |
| ital<br>iciao:<br>s certif<br>rector,  | å   | 25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/   | 26.Place of Death (Check of Other Nursing   |  | dence 6 🗸 Other:                 | Saara   |  |  |  |  |  |
| of V<br>g Phys<br>fter thi   | <u>د</u>  | 1 V res 2 140   |   | 28d. Describe how i                      |                                  | Scerie  |  |  |  |  |  |
| ion<br>tendin<br>eath.<br>for: A   | ation   | 1 V Natural 5 Pending 2 Accident Investigation (Month, Day, Year)   | 1 Yes 2 No  |  |                                  |   |  |  |  |  |  |
| ivis<br>lor At<br>after d<br>Direct<br>d in by   | Certification:  | 3 Suicide 6 Could not be 28e, Place of Injury - At home,  | farm, street, factory, office building, etc.  | 28f. Location (Street<br>or Town, State) | and Number or Rura               | al Route Number, City                         |  |  |  |  |  |
| lospita<br>  hours<br>  uneral   |   | 4 Homicide  29a. Certifier 1 Certifier Physicals. To the best of my knowledge of  | eath occurred at the time, date and place, and  | due to the cause(s)                      | and manner on state              |   |  |  |  |  |  |
| Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physiciae: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as the | edical  | one) 2 Medical Examiner: On the basis of examination and/or and manner stated.  |   |  |                                  |   |  |  |  |  |  |
| F 3 F 3  | ¥   | 29b. Signature and title of certifier   | 29c. License number   |  | d. Date signed (Mont             | h, Day, Year)                                 |  |  |  |  |  |
|  |   | Totaller-Tollet -   |   | Ma                                       | ay 5, 2012                       |   |  |  |  |  |  |
| lov  |   | · · · · · · · · · · · · · · · · · · ·   | )<br>miner = 900 W. Baltimore Street, Ba  | altimore, MD 21                          | 1223                             |   |  |  |  |  |  |
| St   | ate<br>rar  |   |   |  |                                  |   |  |  |  |  |  |
| 6  | 2   | 30. Name and address of person who completed cause of death (Item 23a Patricia Aronica-Pollak MD. Assistant Medical Exa       | O.C.M.E.  miner 900 W. Baltimore Street, Ba   | Ma                                       | ay 5, 2012                       | h, Day, Year)                                 |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Year 2012 Physician/ Webster Erna WILM9 10.40 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Samalitan Hospital Good Baltimore City Baltimore, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min Hours (Month, Day, **Director** 214-24-9649 82 1 🗆 M 2 💢 F Aug. 14,1929 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Baltimore County Baltimore Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? must be USA Funeral 21061 23a 200 Willow Lane er than "natural", or items the Medical Examiner mu death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: 3 X\dowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Homemaking-Own Home 12 yrs. Homemaker ilth and Mental Hygie 27 is marked other r traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Mina Krenkler Otto F. Kuhnke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trauonce. Diane W. Fitzgerald (Daughter) 200 Willow Lane Baltimore, Md. 21061 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Parkwood Cemetery 1 M Burial 2 Cremation 3 Removal from State 5-7-2012 Baltimore, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Sewice Licensee 22. Name and Address of Facility Lassahn Funeral Home, E J Jaes sho 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Cardio myo pathy 16915 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hour 5 Gastrointestinal bieeding Sequentially list conditions. Examine Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Years Atrial Fibrillation and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Years Physician/Medical Congestive Heart failure law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? detached for Month Year Pregnant at time of death Unknown Day 1 Yes 2 No the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia, Hypertension closticidium difficile colins, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of Eastric ulcer, coronary artemy DIJOUSE. 24a. Was an has page 2 autopsy performed death? Hospital or Attending Physician: The l 24 hours after death. Funeral Director: After this certificate h tract infection Yes funeral director, Be 25. Was case referred to hedical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann To Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation filled in by the 2 Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the i only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 2 05/02/12 RES 000 MD

Registrar DHMH 17 Rev 06-2011

State

BALTIMORE

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIRMALASARI

NAY 0 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month White Physician/ Year Kathleen 05:15 PM Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Genesis Multimedical Center Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Social Security Number **Director** 1 🗆 M 2 🔀 Jamaica Usual Residence of Decedent 28a-f shov State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD must be notified Baltimore 1 Yes 2 No ò 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 21215 within 72 hours after death with Avenus items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ò ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Black Specify: "natural" 3 Widowed 4 □ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Nursel Assistant Medical the 7th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Baker trthur rances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trauonce. White Drive Windsor Mill, MD 21244 **UDann** 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 05/19/2012 Pikesville, MD Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Pacility C. Greens Fureral Siving Vauto, Hoad Kandallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Myocardial Infarction disease or condition minutes Medical resulting in death) **Examiner** bronary Artery Disease Sequentially list conditions, Examiner cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or injury that initiated events Hypertension 12015 and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death
Unknown Month Day Year 5 Other (specify) be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Preumonia Records, 1 Yes 2 No 3 Probably 4 Unknown Lung Cancer 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? 10 Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number R097104

Registrar

Genesis multimedical Center 7700 York Road Towson, Maryland 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Michelle E. Kalendek 31. Date filed (Month, Day, Year)

MAY 0 9 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-03411 State of Maryland / Department of Health and Mental Hygiene Virginia P. Witt 2012 14736 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 3, 2012 1002 hrs Madical Examiner Virginia Pauline Witt 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Caroline 102 Fairhaven Court Federalsburg If Under 1 Year If Under 24Hrs. B. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Country) Virginia Director 229-34-1479 1 M 2 X F 82 02/01/1930 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No 28a-f show Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28s-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. "natural", or items 23a or 28a-f sho Examiner must be notified at once. Caroline Federalsburg Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A 21632 102 Fairhaven Court 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes If Yes, Give Year or Dates: 1 Yes 2 X No specify: Specify: White 3 Widowed 4 X Divorced Š 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Assembler 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Issaic Jackson Virgie Spivey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 19a. Informant's Name/Relationship (Type, Print) 2648 Rebecca Lane, Cambridge, MD 21613 Patricia Todd / Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State 05/07/2012 Hanover, Maryland Anatomy Gifts Registry 4 X Donation 5 Offer Specify. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 21076 7522 Connelley Dr., Ste. P, Hanover, MD23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Empyema Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): b. Lung Abscess Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician for use as the burial -Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 2 1 Yes 2 ✓ No 3 Probably 4 Unknown σ. Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has 2 sl performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: **Sital** Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other: Scene DOA this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred ð After 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No Division Pending death. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after To the Funeral Dire Could not be Suicide (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and fittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 4, 2012 O.C.M.E. me and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 32. Registrar's

Laron Locke MD.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Edward Banks Wester 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CIVISTA CENTER MEDICAL PLATA CHARLES If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** . Social Security Number 147–16–3574 Days Hours Min February 9, **Director** XX M 2 D F 88 Yrs. Newark, NJ 1924 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Charlotte Hall St. Mary's Maryland 10e. Street and Number 10f. Zip Code United States Funeral 20622 29449 Charlotte Hall Road of America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces?

X Yes 2 \( \sum \) No Black, White, etc. þ 1XXNever Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Westinghouse Elementary/Secondary (0-12) College (1-4 or 5+) Electric Company Quality Engineer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Helen Prince Banks Edward Wester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Victoria N. Holden/friend 9200 Chenoak Court Parkville, Maryland 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 8 cometery, crematory or other place) Evans Funeral Chapel – Bel Air 1 Burial 2 X Cremation 3 Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Fun ral Service Licer <sup>22</sup> Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Sher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Respir Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami GASTROINTESTINAL burial-trar Physician/Medical INFARCTION MYOCATOIAL the yhd guibt IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a detached i P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BlueraL

PREWROWLA 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has l autopsy performed Yes 2 this certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes ည 1 Nonpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury 5 Pending Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -26262 05/05 MY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIVINGSTONE ROAD. WASHINGTON  $11 \cup 11$ MAN MAY 0 9 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 10:23 A.M Helen Emma West May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year)
July 13, 1920 Days Baltimore, Maryland 184-09-0085 1 □ M 2 🖺 F Director 91 27 is marked other then "natural", or itams 23a or 28a-f show traumatic event, the Medical Examiner munt be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Perry Hall Maryland **Baltimore** 1 Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? United States of America Funeral 21236 9213 Ramblebrook Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 ANo If Yes, Give Black, White, etc. 2 1 Never Married 2 Married within 72 hours aftar Baltimore, Maryland 21215-0036 white 1 ☐ Yes 212X No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and 2 should be filad within 72 Haalth and Mantal Hygians. tem 27 is marked other then " Elementary/Secondary (0-12) College (1-4 or 5+) Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည Katherine MacCloud Wilbur Durner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn Kimmett/daughter 9213 Ramblebrook Road Perry Hall, Maryland 21236 tem 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 7 date parmit, Page 1 and Dapartmant of I Importent: If ite any Injury or ot cernetery, crematory or other place)
Evans, Funeral
Chapel – Bel Air 1 Burial 2 Cremation 3 Removal from State 2012 4 Donation, 5 Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on part, line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury Due to (or as a consequence of): or Attending Physicien: The law requires that the death certificate be executed tha attanding physician and hed for use as tha burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) ata has baan signad by tha a page 2 should ba detached P.O. ing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, 1 TYes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy perform certificata 25. Was case referred to medical of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completaly filled in by the funeral director. 26. Place of Death (Check only one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Speci 1 Tes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 9b. Signature tle of certifier 29d. Date signed (Month, Day, Year) 2

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|   |  |                     | For State Registrar   |   | State of   | f Maryl                    |                                  | partmer<br>ertificat  |                             |                                      |   | lental Hy                               | /giene<br>Reg. No.       | 7111                                     | 2                              | 1473  |
|---|--|---------------------|---|---|--|----------------------------|----------------------------------|---|-----------------------------|--------------------------------------|---|---|--------------------------|--|--------------------------------|---|
|   | Physici  | an                  | 1. Decedent's Nam   |   | NOOLFO   | 0.0                        |                                  |   |                             |                                      |   | 2. Date of D<br>Month                   | eath<br>Day              | ,<br>2012 <sup>Yee</sup>                 | r                              | 3. Time of Death                              |
| 6.  | /Medic<br>Examin   |                     | 4a. Facility Name (   |   | ve street and num  |                            |                                  | 4b. City,<br>Ba1t   |                             | r Location                           | of Death  |   | 4c.                      | County of De<br>1timor                   | eth                            | 10:00a <sup>M</sup>                           |
|   | Funeral<br>Director  |                     | 5. Social Security N 212-42-1   | 347   | Sex<br>1 M 2 □ F   | 7. Age (In )<br>70         | yrs. last birthd<br>Yrs          | ay) If Unde   | 1 Year                      |                                      | r 24 Hrs.<br>Min.                                 | 8. Date of Bi<br>(Month., D<br>3/25/1   | rth<br>ay, Year)<br>942  | 9. B<br>Ma                               | linthplece<br>Country)<br>ryla | o (State or Foreign<br>.nd                    |
| ryland  | how  |                     | Usual Residence o<br>10a. State   | 10b. County   |  | 10c.                       | City, Town o                     | Location  |                             |                                      |   |   |                          |  | 10d.                           | Inside City Limits                            |
| the Ma  | 28a-f  | recto               | MD<br>10e. Street and Nu  | Baltime   | ore  | Ba                         | altimo                           | re  | Code                        |                                      |   |   | 10a Citi                 | zen of What                              |                                | 1 ☐ Yes 2 🙀 No                                |
| ath with  | 23a or   | ralDi               | 2205 S  | mith Ave  | •  |                            |                                  |   | 212                         | 227                                  |   |   |                          | USA                                      | oodmay.                        |   |
| d 21215-0036<br>lifed within 72 hours after death with the Maryland | of other than "natural", or Itame 23s or 28s-f show<br>event, the Medical Examinar must be nullised at | by Funeral Director | 11. Marital Status  1 Never Marr  3 Widowed   | ied 2☐ Married  | 12. Was Dece<br>Armed For<br>1 Tes<br>If Yes, Give<br>Year or Da | ces?<br>2 ⊡ No             | n U.S.                           | 3. Was Dece<br>If Yes, spe<br>1 \( \subseteq Yes                      |                             | lispanic Or<br>an, Mexica<br>Specify |   | ecify Yes or N<br>Rican, etc.)          |                          | 14. Race - Ar<br>Black, Wh<br>Specify: W | nite, etc.                     |   |
| Baltimore, Maryland 21215-0036                                      | Hygiene.<br>other than "natu<br>ent, the Medical   | Completed           | Elementary/Seco   | 15. Decedent's E<br>cify only highest go<br>andary (0-12)<br>12 | ducation<br>rade completed)<br>College (1                        | -4or 5+)                   | - (G                             | cedent's Usu<br>ive kind of wo<br>e. DO NOT u                         | rk done i<br>se retired     | ation<br>during mod<br>d)            | st of work  | ing                                     |                          | nd of Busines                            |                                |   |
| be filed  | nd Mental Hyglene.<br>marked other than<br>imatic event, the Ma  | Be                  | 17. Father's Name   |   |  |                            |                                  | . репсе   |                             | 18. Moth                             | er's Nam  | e (First, Middle                        |                          |  | proy                           | cu  |
| aryland<br>should be  | and Men<br>ie marke<br>aumatic   | ဥ                   | Elmer  19a. Informant's Na  | C.  | Woolf (Type, Print)  | ord                        | 19b. M                           | ailing Address  | (Street                     |                                      | gare  | t<br>ai Route Numb                      | E.                       |  | aill                           |   |
| and 2   | 2 7 2  |                     | Denise M  |   | a (Daug  |                            | 109                              | lst,  | Ave                         |                                      | ., G  | eln Bur                                 |                          |  |                                |   |
| Iltimore  | Uspariment of Hear<br>Important: If Item 2<br>any injury or other<br>once.                             |                     |   | Cremation 3 [<br>5 Other (Spec                                  | (ty)   | State Ba                   | b. Place of Dir<br>altimoi       | sposition (Nai<br>frematery or c<br>re Crei<br>Ion Pai<br>22. Name ar | iatoi<br>k                  |                                      | _5/1  | 0/12                                    | Ba1                      |  | , Ma                           | ryland  |
| <b>B</b>  | any or so  |                     | )   | 2   |  | _                          |                                  |   |                             |                                      |   | udon Pa<br>Baltimo                      | rk F                     | uneral<br>MD 212                         | Hom<br>29                      | ie  |
| /N  | ysician<br>ledical<br>aminer   |                     | 23a. Part1. Enter is short, or hea Immediate Cause disease or condition resulting in death)                                 | (Final  | a  | yoca                       | eath. Do not ralal sequence of): | 7   | rctu                        |                                      | cardiac (   | or respiratory a                        | rrest,                   |  | Inte                           | proximate<br>erval Between<br>set and Death   |
| 60,<br>be executed  | sician and<br>burial-transit   | Examiner            | Sequentially list confrancy, reading to incause. Enter Under Cause (Disease or that initiated events resulting in death) is | injury  | c  |                            | sequence of);                    |   |                             |                                      |   |   |                          |  |                                |   |
| 8760,   | > 4  | icai                |   | - (   | d  |                            |                                  |   |                             |                                      |   |   |                          |  |                                |   |
| ords, P.O. Box 687  | ed by the attending ph<br>detached for use as th   | Physician/Medi      | IF FEMALE: 23b. Was decedent in the past 12 1  Yes 2  9  Unknown  | months?   | 23c. If yes, outc<br>1 □ Live bir<br>4 □ Pregna<br>9 □ Unknow    | nth 2 ⊡F<br>untattimed     | etal death                       | 3 □Ectopic pr<br>5 □ Other (sp  |                             |                                      |   |   | 2                        | 23d. Date of d<br>Month                  | elivery<br>Day                 | y Year  |
| ords, P   | been signed by<br>should be detac  | by                  | Part II. Other signif   | icant conditions  | contributing to de   | ath but not                | resulting in the                 | underlying c  | ause give                   | on in Park                           | un  |   | tobacco u                |  | to the ca                      | ause of death?                                |
| He law  | SCI  | Completed           | h   | yperly  | sidemie  |                            |                                  |   |                             |                                      |   | 24a. Was<br>auto<br>perfo<br>1 \sum Yes | psy<br>ormed?/           | prior to                                 | comple                         | findings available<br>ition of cause of<br>No |
| of Vita<br>Physician:   | is certificate<br>director, pag  | To Be               | 25. Was case referrexaminer? 1 Yes 2 Yes  |   | Hospital: 1 □ In   | patient 2                  | . ☐ ER/Outpat                    | ient 3□ DC  | A Othe                      |                                      |   | me 5 Phesi                              |                          | □Other /Sn                               | acifu)                         |   |
| Vision of   | To the Funeral Director: After this certificate he completely filled in by the funeral director, page  |                     | 27. Manner of Death  1 Natural  2 Accident  | 5 ☐ Pending<br>investigatio<br>6 ☐ Could not b                  | 28a. Date of (Month)   | f Injury<br>, Day Year,    | 28b. Time<br>Injur               | of 2  | 8c. Injury<br>Work<br>1 🗆 ` | at                                   |   | 28d. Describe                           |                          |  | ecity)                         |   |
| Divisio<br>al or Attendi  | al Direct  | Certifi             | 3 Suicide 4 Homicide  | determined  | 286. Place (   | of Injury - Arg, etc. (Spe | t home, farm,<br>ecify)          | street, factory   | , office                    |                                      |   | 28f. Location (<br>City or To           | Street and<br>wn, State) | d Number or I                            | Rural Ro                       | ute Number,                                   |
| Divisio To the Hospital or Attendit within 24 hours after death     | the Funers   | Medical (           | 29a. Certifier<br>(Check only<br>one)   | 1 Certifying Pl<br>2 Medicel Exa                                | nysician: To the t<br>miner: On the ba-<br>and manne             | sis of exam                | knowledge, de<br>ination and/or  | ath occurred investigation  | at the tim                  | ne, date ar<br>pinion, dea           | nd place, a                                       | and due to the<br>ed at the time,       | cause(s)<br>date and     | and manner a<br>place, and du            | as stated<br>ue to the         | i.<br>cause(s)                                |
|   | ToT  | Σ                   | 29b. Signature and  | title of certifier  | Burn   | ress                       | · MD                             |   |                             | 2//                                  | 4   |   | 1                        | signed (Mor                              | 1 -                            |   |
| N   |  |                     | 30. Name and addre  | ess of person who   | completed cause  |                            | tem 23a) (Typ                    | e, Print) 🎵   | EMA                         | SAV.                                 | BER   | MO                                      | ne                       | ) "                                      |                                | -   |
| V ·   | Stat<br>Registra   | .6                  | 31. Date filed (Mont  | h, Day, Year)   | 012 32.  | ristrar's Sig              |                                  | Sark  |                             |                                      |   |   | -                        |  |                                |   |
| C DHMH 1  | 7 Rev 1/20   | 01                  |   |   |  |                            | ORIGI                            | ΝΙΔΙ  |                             |                                      | <del>, , , , , , , , , , , , , , , , , , , </del> |   |                          |  |                                |   |

ORIGINAL

NAME KNOWN TO PHYSICIAN: WARREN, RICHARD A

DHMH 17 Rev 7/2009

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 820PM KICHARD ANTHONY WARREN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CECIL PERRY POIN VA MARYLAND HEALTHCARE SYSTEM 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 4/12/47 1 **№** M 2 □ F Months Hours Min. Mary Land Director 65 217-46-1895 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 USA 3602 Edgewood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status rmed Forces?

Yes 2 No Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1971–86 by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Route Salesman Swanns Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary Louise Patterson Randolph Warren Department of Health an Important: If item 27 is any injury or other traum once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delories A. Warren / Wife 3602 Edgewood Rd. Baltimore, Maryland 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 5/12/12 Baltimore, Maryland Loudon Park Cemetery 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or conclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ months hond disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed lined in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No ဂ္ 4 Nursing Home 5 Residence 6 Wother (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural injury 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Gettly Name Practionar Taths and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Could Name Practionar Taths and fine knowledge and account of the state of the cause (s) and manner stated a could name Practionar Taths and state of the state of (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 7, 2012 HO054439 O Name and address of person who completed cause of death (Item 23a) (Type, Print) VA Maryland Heeth lave System, Perry Point, MD incent A. Giminaro Do 31. Date filed (Month, Day, Year) State MAY 09 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ORIGINAL

For State Registrar State of Maryland / Department of Health and Mental Hygiene 14741 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Vear Wells Sr. May Joseph Flipper 8:10 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore of Baltimore Sinai Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Hours **Director** 217-24-8499 85 1 【**X**M 2 □ F Φ7 19 26 LA Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified MD NA Baltimore 1 Xes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 4600 Norfolk Ave 21216 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. "natural", 3 Divorced 4 Divorced Specify: Black Completed Joseph Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) the 12th grade Tour Superintendent Potal Service Ü.S. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked of permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Augustus Wells Sr. Gertrude S. Brown 19a. Informant's Name/Relationship (Type, Print)
Helen J. Wells-Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4600 Norfolk Ave, Baltimore, Md 21216 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) ☐ Donation 5 ☐ Other (Specify) Vet 5/11/2012 Owings Mills, Md <u>Garrison Forest</u> Signature of Fun Service Licens 22. Name and Address of Eacility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Lymphocystic interstitial pneumonia disease or condition resulting in death) 4 years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of: cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as i IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months? Dav Year Pregnant at time of death 2 No 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş asbestosis 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? hypertension 24a. Was an has page 2 autopsy perform hyperlipidemia this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral s after death. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) aper MP RES -000 May 4, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimure 2401 W. Belvedere Ave. Baltimure MD 21215 YUKI' Elliot Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Registrar

Please Type or Print i Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

| 0 | $\cap$ | 3      | 0 | 8.70 | 7   | 1 | 1 |
|---|--------|--------|---|------|-----|---|---|
| 2 | U      | ALC: N | 4 |      | - / | 4 | 6 |

| Thomas Henry Wa   | ord, Jr. State of Maryland / Department of Health and Mental Hygiene 2012  1- For State Registrar  Certificate of Death Reg. No.   | 471                       |
|---|--|---------------------------|
| Physician<br>Medical Examine  | 1. Decedent's Name (First, Middle,Last)  Thomas Henry Ward Jr.  2. Date of Death Month Day April 25, 2012  3. Time April 25, 2012  | of Death<br>8 hrs         |
| Funeral   | 4a. Facility Name (if not institution, give street and number)  Johns Hopkins Hospital  4b. City, Town, or Location of Death  Baltimore  4c. County of Death  N / A  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (S   | State or                  |
| Director  | Usual Residence of Decedent  | MD                        |
| ith the Maryland 23a or 28a-f show any notified at once.  | MD N/A Baltimore 1 1 X Y  10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  1902 Boone St. 21218 U.S.A.  | ide City Limits  'es 2 No |
| s after death w rall, or items niner must be  | or Dates:  |                           |
| DO36 within 72 hour iene. ner than "natu Medical Exan   | Elementary/Secondary (0-12) College (1-4 or 5+)  11th Grade Handy Man N/A  |                           |
| 21215-0036 old be filed within 7 defined within 8 defined within 8 marked other than its event, the Medica To Be Comple   | Thomas Ward  Sallie Hall  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code   | e)                        |
| Baltimore, MD semit. Pages I and 2 shopertment of Health and Important: If item 27 is injury or other traumati  | Betty Mealy (sister) 6201 Grenfell Loop, Bowie, MD 20720  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State Crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State Crematory or other place)   |                           |
|   | 21. Fature of Funeral Service Livense 21. O's rephydress of Britown Jr. Funeral Home P. 2140 N. Fulton Ave., Baltimore, M.   | A                         |
| Physician Medical Examiner Litausit Examiner  | failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause F for Undorlying Coust.  (Disease or injury that initiated events resulting in death) Last  Between  Between  Due to (or as a consequence of):   | en Onset and<br>Death     |
| ),<br>be execu<br>sician and<br>unial - tra   | UNPENDED AMENDED   | Year                      |
| D. Box 6876 tthe death certificate by the attending phy ached for use as the I  |  | of death?                 |
| Division of Vital Records, P.O. Box 6876( the Hospiral or Attanding Physician: The law requires that the death certificate thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending phy- inherely filled in by the funeral director, page 2 should be detached for use as the b ilical Certification: To Be Completed by Physician/Me |  | ings available            |
| on of Vital Recading Physician: The tuth.  r. After this certificate the funeral director, page tion: To Be Contion: To Be Continued.   | 25. Was case referred to medical examiner?  1  Yes 2 No  26. Place of Death (Check only one)  17. Monors of Death  19. Detection in the property of Death (Check only one)  27. Monors of Death  28. Detection in the property of Death (Check only one)   |                           |
| Division o<br>bepital or Attending<br>hours after death.<br>neeral Director: Aft<br>y filled in by the fune<br>Certification:   |  | Number, City              |
| To the How within 24 h To the Fur completely  | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  The provided HTML representation of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  The provided HTML representation of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  The provided HTML representation of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  The provided HTML representation of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  The provided HTML representation of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  The provided HTML representation of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  The provided HTML representation of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  The provided HTML representation of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and death occurred at the time, date and |                           |
| 2   | 30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223   |                           |
| State<br>Registra   | 1  |                           |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 200 27 4:30 April РМ Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 2111 Moonlight Drive Hampstead If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min **Director** 068-38-7732 1 🗶 M 2 🗆 F 07/24/1953 New York Usual Residence of Decedent 58 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Carroll Hampstead MD 10e. Street and Numbe 10f. Zip Code and Mental Hygiene. is marked other than "natural", or items 23a or renmatic event, the Medical Examiner must be reason. 10g. Citizen of What Country? Funeral 2111 Moonlight Drive 21074 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

X Yes 2 No Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify Specify: Completed 3 Widowed 4 X Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Machine Operator Textile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Department of Health and Ment.
Important: If item 27 is marked any injury or other transmone. Marjorie Jennings Harold Yaeger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2111 Moonlight Drive, Hampstead, MD 21074 Danielle Yaeger / Daughter altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 05/07/2012 Hanover, Maryland 4 X Donation 5 ☐ Other (Specify) Anatany Gifts Registry Signature of Juneral Service Livensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of: cause. Enter Underlying Examin Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last e attending physician end for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate by 2 🗌 No 1 \_\_ Yes Yes 2 Division of Vital the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 읻 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Mcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

MAY U 9 2012

enter St

Name and address of person who completed cause of death (Item 23a) (Type, Print

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0.5 Dorothy A. York 2012 11:50 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 12943 Pine Lane Lusby Calvert 5. Social Security Number . Age (In yrs. last birthday) If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min (Manth/05)/1932 1 🗆 M 2 🗀 F 205-24-6014 80 Pennsylvania **Director** Yrs. Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Calvert Lusby 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 12943 Pine Lane 20657 **USA**  Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes No Specify: If Yes, Give Year or Dates Specify. 3X Widowed 4 □ Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other than " life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker should be filed with and Mental Hygien is marked other th 12 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Novak Elizabeth Granger injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is reany injury or any inj 6416 Olmi Landrith Drive, Alexandria, VA 22307 Deborah L. Norris / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 5/4/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall \ Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cancer una 1/2 Years disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has by page 2 s autopsy performed' certificate 2 🗌 No Yes 2 1 🗌 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after common to the Funeral Director: After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Bhar -2-12 M'D 0068120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

HAY 09

2012

Three Notel Road, Californie,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ri Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner Glen Burnie Anne Arundel 276 McIntosh Dr. 9. Birthplace (State or Foreign Country)
Maryland Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, Funeral 85 220-14-1133 **Director** 1 M 2 XX 4/16/1927 Yrs "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 Tes 2 No Glen Burnie MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21061 276 McIntosh Dr death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No 14 Race - American Indian. Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or may injury or other traumatic event, the Medical Examin any. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🕱 No Specify: White 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Factory Production Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carrol Virginia Simmont Washington George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 276 McIntosh Dr. Glen Burnie, MD 21061 (Daughter) Mary C. Botto 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland Loudon Park Cemetery 5/7/12 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause at each line. Approximate Interval Between Onset and Death Immediate Cause (Final Poysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 month 1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rs after deatn.
ral Director: After this certificate... autopsy performe 2 🗌 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No ER/Outpatient 3 DOA 1 Inpatient 2 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending 2 No Investigation Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined 24 hours a Medical 🖁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar and address of person who completed cause of death (Item 23a) (Prpe, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#23a Per PHY State of Maryland / Department of Health and Mental Hygiene 1 - State 4/24/2012 AACO HEALIH DEPT. CMH Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIL 3 Burroughs 30 PM Robert Gary 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner ARUNDEL (>LEN BURNIE ANNE Baltimore Washington Medical Center 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min 214-46-2065 65 **Director** 1 **X** M 2 □ F Mar. 11,1947 New Jersey Usual Residence of Decede 28a-f show 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location with the Maryland Director MD Anne Arundel Severna Park 1 Yes 2 XNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21146 USA 592 West Drive 12. Was Decedent Ever in U.S. Armed Forces? 1966–1 V Yes 2 No 1970 Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry es anould be filed within 72 feath and Mental Hygiene. m 27 is marked other than "n er traumatic event life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PepsiCo Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Ment. Important; If item 27 is marked any injury or other treesones. 2 Anne Scilipote Isaac Burroughs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severna Park, MD 21146 592 West Drive Linda Burroughs / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of April 20, 20c. Location - City or Town, State 1 🔲 Burial 2 🗓 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Baltimore, MD 4 Donation 5 Other (Specify) Crematory, INC. 2012 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INTRACEREBRAL HEMORRHAGE Physician/ DAY disease or condition Medical resulting in death) Examiner Acute Respiratory Failure if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examin the burial-transit Due to (or as a consequence of): ding physician Physician/Medical certificate be Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Month signed by the at Id be detached for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ည 1 Na Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061832 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DRIVE GLEN, BURNIEMO 301 32. Re strar's Signature State

DHMH 17 Rev 06-2011

Registrar

12-03076 Janet D. Beury

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| 2012 |  | 47 | 4 |  |
|------|--|----|---|--|
|------|--|----|---|--|

| anet D. Deury  |                | 1- For State Control of Death Registrar  |  | eg. No.                        | 12 14/  |  |  |  |  |
|--|----------------|--|--|--------------------------------|---|--|--|--|--|
| Physicia<br>Medical Exami  | in/            | 1. Decedent's Name (First, Middle,Last)  Janet D. Beury  | 2. Date of Dea<br>Month<br>April 20, 2 | th<br>Day Year                 | 3. Time of Death                                |  |  |  |  |
| mealear Exami  |                | 4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location  | of Death                               | 4c. County of Oeat             |   |  |  |  |  |
|  |                | Baltimore Washington Medical Center Glen Burnie  |  | Anne Arundel                   |   |  |  |  |  |
| Funeral<br>Director  |                | 5. Social Security Number 300-36-9743 6. Sex 1 Months Days Hours Min. 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 7. Age (In yrs. last birthday) 9. For Months Days Hours Min. 7. Age (In yrs. last birthday) 9. For Months Days Hours Min. 7. Age (In yrs. last birthday) 9. For Months Days Hours Min. 7. Age (In yrs. last birthday) 9. For Months Days Hours Min. 7. Age (In yrs. last birthday) 9. For Months Days Hours Min. 7. Age (In yrs. last birthday) 9. For Months Days Hours Min. 7. Age (In yrs. last birthday) 9. For Months Days Hours Min. 7. Age (In yrs. last birthday) 9. For Months Days Hours Min. 7. Age (In yrs. last birthday) 9. For Months Days Hours Min. 7. Age (In yrs. last birthday) 9. For Months Days Hours Min. 7. Age (In yrs. last birthday) 9. For Months Days Hours Min. 7. Age (In yrs. last birthday) 9. For Months Days Hours Min. 7. Age (In yrs. last birthday) 9. For Months Days Hours Min. 7. Age (In yrs. last birthday) 9. For Months Days Hours Min. 7. Age (In yrs. last birthday) 9. For Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Age (In yrs. last birthday) 9. Age (In yrs. last birthday) 9. Age (In yrs. last birthday) 1. Age (In yr |  |                                |   |  |  |  |  |
| any  | ł              | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  |  |                                | 10d. Inside City Limits                         |  |  |  |  |
| and f show   | 5              | MD Anne Arundel Crofton  |  |                                | 1 Yes 2 X No                                    |  |  |  |  |
| h the Mary<br>3a or 28a-<br>otified at   | Director       | 10e. Street and Number         10f. Zip Code           1708 Reynolds St.         21114   | 1                                      | 0g. Citizen of What Cou<br>USA | ntry?   |  |  |  |  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mernal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. | Funeral        | 11. Marital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican  | n, Puerto Rican, etc.)                 | 14. Race - Amer<br>White, etc. | rican Indian, Black,                            |  |  |  |  |
| urs afte   | 2              | 3 Widowed 4 Divorced If Yes, Give Year or Dates:  1 Yes 2 X No specify.  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give   | kind of work done                      | 16b. Kind of Business/         |   |  |  |  |  |
| 036<br>ithin 72 ho<br>ne.<br>r than "na<br>fedical Ex  | Completed      | Elementary/Secondary (0-12)  College (1-4 or 5+)  S+  Realtor  | use retired)                           | Real Esta                      | te  |  |  |  |  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other trammatic event, the Medical   |                |  | r's Name (First, Middle, I             | ,                              |   |  |  |  |  |
| 212' vuld be Menta marke   | To Be          | Edgar T. Duke  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Num   | Vette Steri                            |                                | e, Zip Code)                                    |  |  |  |  |
| MD d 2 sho lith and 27 is numati   |                | Ronald H. Beury / Spouse 1708 Reynolds St.   |  |                                |   |  |  |  |  |
| ore, of Hea  |                | 20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)   | Date                                   | 20c. Location - City or        | , -   |  |  |  |  |
| fim Pagir. Pagrument   |                | 4 Donation 5 Other Specify: Lakemont Mem. Gards 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit  |  | Davidsonv                      | ille, MD  |  |  |  |  |
| Ba<br>Perm<br>Depa<br>Imp  |                | 6512 NW Crain H  | DCGII I GII                            |                                | 5   |  |  |  |  |
| Physician<br>/Medical  | 7              | 26a P rt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as called a failure. List only one cause on each all the cause of the cause     |  |                                | Approximate Interval<br>Between Onset and       |  |  |  |  |
| Examiner   |                | Immediate Cause (Final disease or condition resulting in death)  A Hypertensive Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):   |  |                                | Death   |  |  |  |  |
|  |                | Sequentially list conditions, b  |  |                                |   |  |  |  |  |
|  | Examine        | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated   |  |                                |   |  |  |  |  |
| uted<br>d<br>ansit   | Exa            | events resulting in death) Last  Due to (or as a consequence of):  d.  |  |                                |   |  |  |  |  |
| e exection and initial - th  | Medical        | UNPENDED AMENDED   |  |                                |   |  |  |  |  |
| 8760<br>ificate t  | n/Me           | IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic  | c pregnancy                            | 23d. Date of deliver           | y<br>Day Year                                   |  |  |  |  |
| Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit  | Physician/     | past 12 months?  1  Yes 2 No 9 Unknown  1  Unknown  2  Fetal death 3 Ectopic 5 Other (Specify) 9 Unknown   |  |                                | 1001  |  |  |  |  |
| P.O.   | و              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa  |  | bacco use contribute to        | the cause of death?  pably 4  Unknown           |  |  |  |  |
| cords<br>e law requi<br>e has been   | Completed      |  | 24a. Was a autop                       | sy prior to o<br>med? death?   | topsy findings available completion of cause of |  |  |  |  |
| tal Rec  |                | 25. Was case referred to medical 26.Place of Death   | 1 ✓ Yes :<br>(Check only one)          | 2 No 1 Ye                      | es 2 No   |  |  |  |  |
| Vita   | To Be          | examiner? 1 Yes 2 No  Hospital: 1 Inpatient 2 FR/Outpatient 3 DDA  Other4  |  | Residence 6 Other              | T:  |  |  |  |  |
| on of ading Pt. th After e funeral   |                | 27. Manner of Death 28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work  |  | now injury occurred            |   |  |  |  |  |
| Visio  | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, et   | c. 28f. Location (S                    | Street and Number or Ru        | ral Route Number, City                          |  |  |  |  |
| Di<br>spital cours a<br>nours a<br>filled  | Cert           | 4 Homicide determined (Specify)  | or Town, S                             | tate)                          |   |  |  |  |  |
| To the Ho<br>within 24 I<br>To the Fu  | Medical        | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placency one)  2 Medical Examiner: On the basis of examination and/or-investigation, in my opinion, death occurred.   |  |                                |   |  |  |  |  |
| To will To corr  | Mec            | 29b. Signature and title of certifier 29c. License number  |  | 29d. Date signed (Mo.          | nth, Day, Year)                                 |  |  |  |  |
|  |                | 0.C.M.E.   |  | April 21, 2012                 |   |  |  |  |  |
| LALIE  | 1              | Name and a dress of person who comply dicay of death, item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimbre Street,  | Baltimpre. MD 212                      | 223                            |   |  |  |  |  |
| St   | ate            | 31. Date filed (Month, Gay Year) 4 0010 32. Registrar's Signature  |  | <del>-</del>                   | -   |  |  |  |  |
| Regist   |                | APR 24 ZUIZI / Basea A.  |  |                                |   |  |  |  |  |

....

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 14748 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 14, Day 2012 Year Physician/ 2:56 P M Bertha Josephine Buss Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Min 153-26-7255 Director 1 □ M 2 🛣 F Oct. 22, 1934 New Jersey 77 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Funeral Director 28a-f 1 X Yes 2 No Maryland | Prince George's Bowie 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? ms 23a or must be r 20715 USA 12640 Millstream Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or ite Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Home Maker Own Home Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Josephine Chron Justin C. Smith, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12640 Millstream Drive Bowie, MD 20715 George E. Buss/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4/23/2012 4 Donation 5 Other (Specify) Waldorf, MD Huntt Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 121 Tul 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ TACHYCARDIA LETTING TU CARDIAC a VENTRI CULAR disease or condition Medical resulting in death) ARRESS **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DYSPHAGIA Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes LEUKOCYTOSIS 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 prior to completion of cause of death? has completely filled in by the funeral director, page 2 within 24 hours after death.

To the Funeral Director: After this certificate I 2 No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 065292 d address of person who completed cause of death (Item 23a) (Type, Print) medical Parhasay

State Registrar egistrar's Signati

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14749 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 17 Physician/ <sup>□</sup>2012 3:30 John Andrew Blackwell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brighton Gardens Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 578-34-8870 **Director** 1 COM 2 - F 84 12/26/1928 Washington,D.C. Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Prince George's Riverdale 1XX Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 4900 Nicholson Street 20737 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. or by 1 Never Married 2 XX Married 1 XX/es If Yes, Give 2 🗆 N 3altimore, Maryland 21215-0036 han "natural", o Specify: White 1 Yes 2XXNo Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Mechanica1 Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the -12-Steam Fitter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Otho L. Blackwell Dorothy L. Portch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1302 Double Gate Court, Donna Warren = Daughter-in-law 1 and 2 s of Health a item 27 Davidsonville, Md. 21035 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If ite any injury or ot once. Page 1 1XX Burial 2 Cremation 3 Removal from State Ft.Lincoln Cemetery 4/23/2012 Brentwood, Md. 4 Donation 5 Other (Specify) Robert E. Evans Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 16000 Annapolis Road, Bowie, Md. 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hlahelmers 15 case disease or condition resulting in death) Medical s a consequence of **Examiner** Sequentially list conditions, Due to (or as a consequence on). if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit Due to (or as a consequence of): resulting in death) Last attending physician /Medical The law requires that the death certificate be-Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at d be detached for Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Discere Division of Vital Records, (ardiovercular 1) is earl Cerebrovariolar 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of autopsy death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director, After this certificate I Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) ပ 1 Tes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my spewledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4801 160551

State Registrar

APR 2.0 2012

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours 923 Pennsylvania Director Usual Residence of Decedent octant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Wicomico Salisbury 1 ☐ Yes 2X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 4228 Oakland School Road 21804 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. X Yes 2 No 1944-Yes, Give Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: 1946 White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Pharmaceutical 10 Security Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 욘 Beers С. Joseph Mary Orbine iff. Page 1 and 2 shours of Health and Mr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Beers – Sister–in–law 4228 Oakland School Road, Salisbury, Maryland 21804 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Memorial Pk. 4-27-2012 Salisbury, Maryland 21. Signature of Funeral Service Licey ee 22. Name and Address of Facility Bounds Funeral Home Ε. Main Street, Salisbury, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SCV disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Disease arkin ons Secretarially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed Demen After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 24a. Was an autopsy performed Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 5 Pending Accident
Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1C Name and address of person who completed cause of death (Item 23a) (Type, Print) #504B Salisbury IVA Mil tord 57 106

State

Registrar

31. Date filed (Month, Day, Year)

24

Registrar's

|                            |  |                  | AMEND PII, 25, P  1 - State Amend Ite Registrar  | EType or Pr<br>ER MD G93(<br>State of M<br>Em 5 per f                      | int in E<br>8/22<br>laryland<br>h,g92   | Black Ir<br>d Dep<br>7,05/1            | ndelible<br>RT<br>artment<br>4/2012  | Ink. E  | nsure A   | <b>Ali Copie</b><br>Mental Hy       | es Ar   | e Legible  | e.                                  | 475            |
|----------------------------|--|------------------|--|--|---|--|--|---|---|-------------------------------------|---|--|-------------------------------------|----------------|
|                            | Physicia<br>Medi   |                  | 1. Decedent's Name (First, Middle, La<br>Virginia M. Brov  | st)  |   | Cer                                    | uncate   | or Deal   |   | 2. Date of Do                       |   | ay Yea   | 3. Time                             | of Death       |
|                            | Examir<br>Funeral<br>Director  |                  | 2.0 21 2100  | ex 7. As   | <u>l Lí</u><br>ge (In yrs. la   | st birthday)<br>Yrs.                   | Sa<br>If Under 1   | ish   | nder 24 Hrs.<br>urs Min.  | 8. Date of Bi<br>(Month, D<br>Aug 2 | irth  | C. County of De 9. E   |                                     | or Foreign     |
|                            | ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | Director         | Usual Residence of Decedent  10a. State  10b. County  MD  Wicomic  | co   | 1   | , Town or Loc                          | У  |   |   |                                     |   |  | 10d. Inside                         | City Limits    |
|                            | leath with the<br>items 23a or<br>er must be r   | Funeral D        | 10e. Street and Number  29217 Doubletree  11. Marital Status   | 12. Was Decedent   | 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.  13. V  13. V  14. Decedent Ever in U.S. 15. Decedent Ever in U.S. 16. Decedent Ever in U.S. 16. Decedent Ever in U.S. 16. Decedent Ever in U.S. 17. Decedent Ever in U.S. 18. Decedent Ever in U.S. 18. Decedent Ever in U.S. 19. Decedent Ever i |  |  | 801<br>of Hispanio  | o Origin? (Spe  | ecify Yes or No                     | 10g. Citizen of What Country?  USA  14. Race - American Indian, |  |                                     |                |
| 21215-0036                 | hours after d<br>natural", or i<br>lical Examin  | þ                | 1 X Never Married 2  Married 3  Widowed 4  Divorced  15. Decedent's B  | 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates.                                    |   |  |  | as Decedent of Hispanic Origin? (Specify Yes or Nes, specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2 Mo Specify:  ent's Usual Occupation |   |                                     |   | Black, White, etc. African— Specify: American  Mind of Rusiness Industry |                                     |                |
| d 21218                    | ed within 72<br>Hygiene.<br>other than "part, the Med  | Be Completed     | (Specify only highest gi Elementary/Seconday (0-12) n/a  17. Father's Name (First, Middle, Last)   | Elementary/Seconday (0-12) College (1-4 or 5-                              |   |  |  | i/a   | n 16b. Kind of Business Industry n/a  Mother's Name (First, Middle, Maiden Surname) |                                     |   |  |                                     |                |
| Maryland                   | should be fill<br>and Mental<br>is marked or<br>raumatic eve   | ্ব               | unknown<br>19a. Informant's Name/Relationship (1   |  |   |  | -  | reet and Nu   | tha Sm<br>umber or Rura   | ullen al Route Numb                 | er, City c  | or Town, State, .  |                                     |                |
| Baltimore, N               | permit. Page 1 and 2<br>Department of Health<br>Important: If item 27<br>any injury or other to<br>once.   |                  | Rose Smith/sister  20a. Method of Disposition  1 Description   1 Cremation   3 Cremation   4 Cremation   5 Crematical   5 C | Removal from State   | , ce  | ace of Dispo<br>emetery, cren          | Doubl sition (Name of the Cemeter  Cemeter  The Company of the com | of<br>r place)  |   | e, Salis<br>Date<br>1/2012          | 20c. l  | y, MD 2<br>Location - City<br>arptown                                    | or Town, State                      |                |
| Balti                      | permit. Page<br>Department<br>Important: I<br>any injury o   |                  | 21. Signature of Funeral Service Licen 23a. Part 1. Enter the disease, or com  | Valsor   |   | 22<br>I<br>1                           | Name and A<br>EWIS N<br>618 We   | ddress of F<br>Watest Rd  | acility<br>son Fu<br>sal  | neral l<br>isbury                   | Home<br>, MD  | _  |                                     |                |
|                            | nysician<br>Medical<br>Examiner  | 5 10             | shock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)   | a. Due to (or as   | e.<br>No  | myo                                    | PAT  |   | Tas ou diac C   | or respiratory a                    |   |  | Approxim<br>Interval B<br>Onset and | etween         |
| .60                        | cate be executed physician and sthe burial-transit   | edical Examiner  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  | b. Due to (or as  c. Due to (or as   |   |  |  |   |   |                                     |   |  |                                     |                |
| . Box 68760                | ath certifi<br>attending<br>for use as   | Physician/Medica | IF FEMALE: 23b. Was decedent pregnant in the past 12 protitis? 1   |  |   |  |  |   |   |                                     |   | 23d. Date of delivery<br>Month Day Year                                  |                                     |                |
| rds, P.O.                  | requires that the de<br>been signed by the<br>should be detached   | Completed by Pl  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  END STAGE RENAL DISEASE  |  |   |  |  |   |   |                                     | e. Did tobacco use contribute to the cause of de                |  |                                     | Unknown        |
| al Reco                    | ician: The law i<br>certificate has b<br>ector, page 2 s   | Be Compl         | 25. Was case referred to medical examiner?   |  |   |  | 2  | 6. Place of   | Death (Check  | 1                                   | opsy<br>ormood?   | prior to<br>death?   |                                     |                |
| of Vit                     | ig Physic<br>er this ce<br>neral direc   | 욘                | 1 ☐ Yes 2 🖾 No<br>27. Manner of Death  | Hospital:  1  Inpat  28a. Date of inju (Month, Da                          | iry [   | ER/Outpatien<br>28b. Time of<br>injury | 28c.   | Injury at   |   | ome 5 Resi                          |   | y occurred   | ecify)                              |                |
| Division of Vital Records, | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,   | d Certificate:   | Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be 4 Homicide determined   | n  | ury - At hon  |  | М  | work?<br>1  Yes   |   | 28f. Location (<br>City or To       |   | nd Number or F<br>e)   | Rural Route Nur                     | nber,          |
|                            | To the Hospital or within 24 hours afte To the Funeral Dirk completed filled in h  | Medical          | (Check 2 Medical Examonly one) 3 Certifying Nur  29b. Signature and title of certifier   | sician: To the best of<br>iner: On the basis of a<br>se Practioner: To the | examination<br>best of my   | and/or invest<br>knowledge, d          | eath occurred  | ppinion, dea<br>at the time,<br>cense numb  | th occurred at<br>date and plac<br>per  | the time, date<br>e, and due to the | and place<br>ne cause(<br>29d. Da                               | e, and due to the<br>(s) and manner a<br>ate signed (Mor                 | e cause(s) and nas stated.          | nanner stated. |
|                            | 200  |                  | 30. Name and address of person who or Ghulum Waris,  | completed cause of c   | leath (Item 2   | 23a) (Type, P                          | rint)  | 205   | 8410  | ) N                                 | 0   | 4/11   | 112                                 |                |
|                            | Stat<br>Registra   | ie<br>ar         | 31. Date filed (Month, Day, Year) APR 17 201   |  | ar's Signatu  | ire Span                               | Kal .  | OI P  | ww D  | ury II                              | 01  | 21001  |                                     |                |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ Day 2012 April John Blische PM 14, 7:03 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Salisbury Wicomico 1112 S. Schumaker Dr., Unit 202 . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 **X** M 2 □ F 218-07-0167 Director 91 09/04/1920 Maryland Usual Residence of Decedent 28a-f show 10c City Town or Location items 23a or 28a-f sho ner must be notified at 10d. Inside City Limits Director 1 K Yes 2 □ No Maryland Wicomico Salisbury 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 1112 S. Schumaker Dr., Unit 202 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ed other than "natural", or ite event, the Medical Examiner Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 1 V Yes 2 No
If Yes, Give Merchant
Year or Dates. Marino Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: White Completed Marine 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S.Merchant Marines 12 2 Master Mariner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of မ Marian Swenson Adolph Blische permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic or 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Blische/Daughter 506 Holly Ridge Court, Salisbury, MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/17/2012 Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknown P.O. I ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas autopsy performed? Yes 2 certificate 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director: After th Certificate: 28c. Injury at iniury Natural 5 Pending work? Accident 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature and title of certifier 047094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-DIVISION Shew NATESAN 1415 VU 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day PHYLLIS Virginia Bowles 12:05 A M April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NMS Healthcare of Hagerstown <u>Maryland</u> Hagerstown If Under Social Security Number Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) U1v 27,1938 Months Hours Min. West Virginia Director 219-34-5115 73 July Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14014 Marsh Pike 21742 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify. Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 9 Own Home permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other 1 any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lester David Mathis Vesta Belle Barthelow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bobby L. Bowles 19 Searcy Drive, Hampton, Virginia 23666 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04-27-12 Hagerstown, Maryland Hagerstown Crematory Signature of Funeral Service Licensee Andrew K. Coffman Funeral Home, Inc. R. hoel Bra East Antietam Street, Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ brillation disease or condition resulting in death) Medical Due to (or as a consequence of Examiner < Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a no ospital or Attending Physician; The law requires that the death certificate be executed hours after death. diom and resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year signed by the aid be detached to 1 ☐ Yes ∠ ¥ 9 ☐ Unknown ☐ Unknowr Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has le 2 autopsy page death? performed certificate Yes 2 No s after death.

I Director: After this certificd in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 1 🗌 Yes 2 DNo Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D060396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 MURSHED FARID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14755 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRI, 825 PM Physician/ Gary Lindelle Crane 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctor's Community Hospital Lanham 8. Date of Birth (Month, Day, Year) If Under 24 Hrs Hours Min. Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Director 235-58-3700 1 X M 2 🗆 F Sep. 8, 1939 West Virginia 72 Usual Residence of Decedent show or items 23a or 28a-f sho miner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No Maryland | Prince George's Bowie 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20720 USA 13011 Martha's Choice Circle 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1963- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) and Mental Hygiene.
Is marked other than "natural", or item 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 X Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Letter Carrier U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Granville Wesley Crane |Maxine Velma Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13011 Martha's Choice Circle Bowie, MD 20720 Carol Geneva Borchardt/ Companion 20b. Place of Disposition (Name of cemetery, crematory or other place)
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/23/2012 Davidsonville, MD 22. Name and Address of FacilityRobert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 104 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final .Ph, sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and I for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Unknown 1 Yes 2 L 9 Unknown 2 No the signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has build director, page 2 s autopsy perform death? Yes 2 DA or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 INO Other: ျ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 1 npatient 2 this 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompletely filled in by the funer Natural 5 Pending work?
1 Yes 2 🗌 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) determined Hospital Medical Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tit e of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

12-03001 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Adrian Louis Corbin State of Maryland / Department of Health and Mental Hygiene 2012 14756 1- For State Certificate of Death Reg. No. Realstrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day April 17, 2012 Adrian Louis Corbin 0452 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 100 East Carroll Street Salisbury Wicomico 5. Social Security Number If Under 1 Year 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) If Under 24Hrs. **Funeral** Months Hours Days Director Country) MD 7-28-1970 220-15-2473 1X M 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits iny 10a. State 1 Yes 2 X No or items 23a or 28a-f show must be notified at once. Wicomico Eden MD hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 26155 Walnut Tree Road 21822 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Conduction, Armed Forces? Alr Force eyes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? Air 1 X Yes 2 No White, etc. 1 Never Married 2 X Married 4 Divorced If Yes, Give Year 1 988 – 2000 1 Yes 2 X No specify: Specify Black Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 it marked other than "natural", injury or other fraumatic event, the Medical Examiner. Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self-employed Information Technician 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Betty Wessels å William Corbin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20901ဥ 19a. Informant's Name/Relationship (Type, Print) Kelly E. Corbin/Wife 9412 Saybrook Ave, Silver Springs, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) LLC 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Direct Cremation, 4-23-2012 Dover, DE 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PO Box 326 McPherson Fun Serv. ma Milford, DE Approximate Interval Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and failure. List only one cause on each line. /Medical Death a, Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Day past 12 months? 2 Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown s been signed by the att should be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 至 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy r this certificate has b al director, page 2 sh death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 🗸 Inpatient Other | Nursing Home 5 Residence 6 ER/Outpatient 3 DOA 1 V Yes After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 V Natural 5 Pending 1 Yes 2 No letely filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 18, 2012 alleste O.C.M.E. TC

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6 Day Month 4 Physician/ 20<sup>4</sup>fa2 8:05p Gwendolyn Denise Coles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign **Funeral** Days Hours Min. Country) Director 228-86-5818 1 🗆 M 2 💢 55 7-22-1956 VA Usual Residence of Decedent 28a-f show 10a. State aţ 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 Yes 2 No VA Northampton Cape Charles or 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a must I 22807 Bayview Circle, Apt 2 23310 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Army
Yes 2 No
No
No 14. Race - American Indian, Black, White, etc. Examiner ò Completed by 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Yes, Give SpeciBlack "natural", 3 Widowed 4 Divorced Year or Dates. Army 72 hours other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Technician Mac Trucks, Incorp Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Carlisle J. Coles Mary Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 9008 Tarpleys Circle, Rosedale, MD 21237 Demetrice Coles/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Page 1 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Μt Calvary Cem 4-13-2012 Exmore, VA 21. Sign tur of Funeral Service Licensee Bennie Smith 917 W. Isabella St. Salisbury, MD 21801 Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician averealie disease or condition resulting in death) Laur Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year signed by the a 2 No Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has page 2 autopsy 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one)

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 2 To the MA

After this funeral

s after death. I Director: Aft the

24 hours

filled in by

Registrar

State

examiner?

27. Manner of Death

1 X Natural

Accident

29b. Signature and title of certifie

W

31. Date filed (Month

Suicide

4 Homicide

29a. Certifier (Check

은

Certificate:

Medical

2 🗷 No

5 Pending

Investigation 6 Could not be

determined

Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 670

28a. Date of injury (Month, Day, Year)

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Charle

28b. Time of

iniurv

Other:

work?
1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

4105

29c. License number

D72139

28c. Injury at

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Suite

4 Nursing Home 5 Residence 6 Other (Spec

Ballinoso

28d. Describe how injury occurred

28f, Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

Hospies

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ April Allan Cleo Collier 2012 3:13 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7417 Tarfside Lane Gaithersburg Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 214-48-8882 1 XM 2 F 64 Yrs Usual Residence of Deceder 1947 21. Washington, DC 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits her must be notffied at Director 1 Yes 2 K No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 7417 Tarfside Lane 20879 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 Ā No Black, White, etc ð 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify:White Completed 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Montgomery County Ith and Mental Hygie 27 is marked other traumatic event, # <u>Media Services Technician</u> Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Allan R. Collier Frances E. Cummings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry J. Collier/Brother Windmill Lane, Silver Spring, MD 20905 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State April 25 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA Metropolitan Crematory 2012 Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W.. Silver Spring. 23a. Part 1. Enter the disease, or complications that or use the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Atherosclerotic Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause in librate or injury Due to (or as a consequence of) attending physician and for use es the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death this certificate hes been signed by the a ral director, page 2 should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 第 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2X No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗵 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After Hospital or Attending 24 hours after death. 5 Pending 1 X Natural injury work? 2 | No Accident Investigation filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number D35965 April 23, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #300 5 David B. Harding, MD 18111 Prince Philip Drive, Olney, MD 20832 31. Date filed (Month, istrar's Signature State

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 04/27/2012 0910 AM Nora P. Dennis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Citizens Care Center Harford Havre de Grace If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Maryland 1 □ M 2 😿 F Months Yrs 217-05-7910 91 **Director** 26/1920 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 X Yes 2 No Maryland Harford Havre de Grace 10f. Zip Code 10e. Street and Number ò 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be United States of Funeral 100 Revolution Street Apt 507 21078 America 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Black, White, etc. þ 1  $\square$  Never Married 2  $\square$  Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 √ Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) th and Mental Hygiene.

27 is marked other than traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Consultant Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Wright Virginia Singleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, 619 Cole Street, Elva Kelley (Niece) Perryville, MD 21903 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Aberdeen, 4 ☐ Donation 5 ☐ Other (Specify) Mem. Gdns05/01/2012 Maryland 22. Name and Address of Facility Zellman Funeral Home, P.A. S.Washington St. Havre de Grace. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: been signed by the attendin should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month 5 Other (specify) Month Dav Year Pregnant at time of death significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death þ 1 Yes 2 No 3 Probably 4 Unknown Completed 4b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? prior to completion death? After this certificate 1 Yes 25. Was case referred to redical funeral director, 26. Place of De // (Check only one) Be examiner? Hospital: Other: 1 Tyes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Man or of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural 2 🗌 No within 24 hours after death.

To the Funeral Director: At Accident
Suicide Investigation 1 Yes completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗔 only one) 29b. Signata re and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) State Registrar

A

0160

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 21, 2012 Leona Evelyn Dusza 5:20 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Citizens Care and Rehabilitation Center Frederick Frederick Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 193-18-0006 **Director** 91 1 🗆 M 2 🗶 F March 27, 1921 Pennsylvania Usual Residence of Deceden 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Monrovia 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rms 23a or Funeral 11408 Ridge Lane 21770 United States of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 1 Never Married 2 Married 1 Yes 2 No Specify. White Completed 3 Widowed 4 Divorced Specify. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4 or 5+) 12 Postal Service Mail Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ William Clarkson Mary Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Dusza / Son 11411 Ridge Lane, Monrovia, Maryland 21770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State Department of Important: If any injury or once, Lloyd Cemetery April 27, 2012 4 Donation 5 Other (Specify) Ebensburg, Pennsylvania Signature of Funeral S 22. Name and Address of Facility **Keeney & Basford P.A. Funeral Home** M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) as a consequence of Sequentially list conditions Due to (or as a consequence bij. cause. Enter Underlying Exami Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed

Ph si ian Medical **Examiner** 

the burial-transit

as

attending physician

signed by the at

has page 2

Director: After this certificate

director,

funeral

filled in by the

Be

မ

Certificate:

Medical

29a. Certifier

(Check

25. Was case referred to medical

To the Hospital or Attending Physician:

hours after death.

within 24 hours a

To the Funeral C

certificate be

P.O. Box 68760

Division of Vital Records,

show

28a-f

ö

items death

ö

"natural"

al Hygiene.

of Health and Mental H If item 27 is marked ot I other traumatic ever

If item 27 i

injury or

Medical Examiner

the

with t

Maryland 21215-0036 be filed within 72 hours after

altimore,

notified at

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

26. Place of Death (Check only one) Other

Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 No 1 Yes

2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 5 Pending injury Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

Nursing Home 5 Residence 6 Other (Specify, 28c. Injury at 28d. Describe how injury occurred work? 2 🗌 No

City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination a tion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best 29b. Signature a

occurred at the time, date and place, and due to the cause(s) and manner as stated Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number,

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

Kaufmann MD300 West NInth Street, Frederick, Robert L. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

 $\mathcal{O}$ 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

|                            |  | 1            | 4 101   | Maryland / Dep  |  |  | <i>l</i> lental Hyg                      |  | 0 11761                                  |
|----------------------------|--|--------------|---|---|--|--|--|--|--|
|                            |  |              | State Registrar   | Ce  | rtificate of De  | ath                                    | Re                                       | eg. No. 201                                  | 2 14/61                                  |
| п                          | Physicia   | ın/          | Decedent's Name (First, Middle, Last)   |   |  |  | 2. Date of Deatl<br>Month                | Day Yea                                      | 3. Time of Death                         |
|                            | Medic  | cal          | Mary Ellen Dow  4a. Facility Name (if not institution, give street and numb                                       | ming  | 1,, 20, 7  |  | 04                                       | 7 7 7 7                                      |  |
|                            | Examin   | er           | PENINSYLA REGIONAL MEDICA   | · ·   | 4b. City, Town, or Lo                                    | SOURY                                  |  | 4c. County of De                             |  |
|                            | Funeral  |              |   | . Age (In yrs. last birthday)                             | If Under 1 Year If                                       | f Under 24 Hrs.                        | 8. Date of Birth                         | g. E   | Birthplace (State or Foreign             |
|                            | Director   |              | 221-32-4461 1 M 2 16 F  | 66 Yrs.   | Months Days F  | Hours Min.                             | (Month, Day,                             |  | Country)                                 |
|                            | ld<br>now  | Ļ            | Usual Residence of Decedent  10a, State  10b, County  | 10c. City, Town or Lo                                     | ocation  |  | 12/06/1                                  | 945   Ne                                     | W York  10d. Inside City Limits          |
|                            | arylar<br>a-f sł<br>fied   | Director     |   |   |  |  |  |  | 1 X Yes 2 No                             |
|                            | or 28<br>or 28<br>or oti   | Ö            | Maryland Wicomico  10e. Street and Number   | Salish  | 10f. Zip Code  | -                                      | 1  | 0g. Citizen of What                          |  |
|                            | e filed within 72 hours after death with the Maryland<br>tral Hygiene.<br>ed other than "natural", or items 23a or 28a-f show<br>event, the Medical Examiner must be notified at   | Funeral      | 418 Pennsylvania Ave.   |   | 21801  |  |  | USA  | ,-                                       |
|                            | death<br>items<br>ner m  |              | 11. Marital Status 12. Was Deceder Armed Force  |   | Was Decedent of Hispa<br>If Yes, specify Cuban, N        | anic Origin? (Spe                      | ecify Yes or No-                         |  | nerican Indian,                          |
| 36                         | after (<br>", or<br>camir  | l by         | 1 X Never Married 2 Married 1 X Yes 2   | Marine  | 1  Yes 2 No S  |  | riloan, etc.,                            | Black, Wh                                    |  |
| 9                          | atura<br>cal Ex  | Completed    | 3 Widowed 4 Divorced Year or Date   | s. Corp   | dent's Usual Occupatio                                   |  | 1.                                       |  | White                                    |
| 215                        | thin 72 h<br>sne.<br><b>than "n</b><br>ne Medi   | ld m         | (Specify only highest grade completed)  | (Give   | kind of work done during NOT use retired)                |  | ing                                      | 16b. Kind of Busines                         | ss/Industry                              |
| 212                        | iled within<br>I Hygiene.<br>other tha<br>rent, the N  |              | Elementary/Secondary (0-12) College (1-4  | Soci  | al Worker  |  |  | State of                                     | Maryland                                 |
| nd                         | filed<br>tal Hy<br>d oth<br>event  | To Be        | 17. Father's Name (First, Middle, Last)   |   | 18   |  | e (First, Middle, M<br>Ruth Joh          |  |  |
| yla                        | should be file<br>n and Mental I<br>7 is marked c<br>raumatic eve  | ٦            | Ivan Paul Downing   |   |  | петеп                                  | KULII JOII                               | HSOH   |  |
| Maryland 21215-0036        | CI + + +   |              | 19a. Informant's Name/Relationship (Type, Print) Carol L. Gathagan/Sister   |   | ng Address (Street and<br>L <b>Grandview</b>             |  |  |  | Zip Code)                                |
| ē,                         | ge 1 and 2 should be<br>nt of Health and Men<br>I if item 27 is marke<br>or other traumatic  |              | 20a. Method of Disposition  | 20b. Place of Dispo                                       |  | -                                      | <del>-</del> -                           | 20c. Location - City                         | or Town State                            |
| altimore,                  | permit. Page 1 and 3<br>Department of Healt<br>Important: If item 2<br>any injury or other<br>once.  |              | 1 Burial 2 Cremation 3 Removal from S<br>4 Donation 5 X Other (S <b>Emit onlonent</b>                             | tate Springhi   | matory or other place) LLI Memory                        |  |  |  |  |
| atti                       | permit. Pag<br>Departmen<br>Important:<br>any injury<br>once.  |              | 1 Superal Service Licensee  |   | Gardens  |  | /2012                                    | Hebron,                                      |  |
| Ω                          | an II De   |              | David H. Gompson  | CFSP 5  | 501 Snow Hi  | ill Rd.,                               | Salisbu                                  | ry, MD 21                                    | Association<br>804                       |
|                            |  |              | 23a. Part 1. Enter the disease, or complications that cal<br>shock, or heart failure. List only one cause on each | used the death. Do not ent                                | er the mode of dying, s                                  | uch as cardiac c                       | or respiratory arres                     | st,  | Approximate<br>Interval Between          |
| may.                       | Physician/   |              | Immediate Cause (Final disease or condition   | euniona   |  |  |  |  | Onset and Death                          |
| Ì                          | Medical<br>Examiner  |              | resulting in death)  Due to (or   | as a consequence of):                                     |  |  |  |  |  |
|                            |  | ler          | Sequentially list conditions, if any, leading to immediate b. Due to (or  | as a consequence of);                                     | eloma  |  |  |  |  |
|                            | ted<br>Insit   | Examiner     | cause. Enter Underlying<br>Cause (Disease or injury   | as a consequence on. U                                    |  |  |  |  |  |
|                            | execu<br>in and<br>ial-tra   |              | that initiated events c. Pue to (or   | as a consequence of):                                     |  |  |  |  |  |
| 00                         | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | edical       | d   |   |  |  |  |  |  |
| Box 68760                  | rtificar<br>ing ph<br>e as tl  | Me           | IF FEMALE:  |   |  |  |  |  |  |
| ×6                         | ith cel  | ian/         |   | rth 2 🗌 Fetal death 3 🛚                                   |  |  |  | 23d. Date of o                               | lelivery<br>Day Year                     |
| ĕ                          | the a  | Physician/M  | 1 Yes 2 No 4 Pregna 9 Unknown 9 Unknown   |   | Other (specify)  |  |  | Worth  | Day Teal                                 |
| P.O.                       | that the   | by Pr        | Part II. Other significant conditions contributing to dea   | th but not resulting in the t                             | underlying cause given                                   | in Part I.                             | 23e. Did toba                            | acco use contribute                          | to the cause of death?                   |
| <u>'S</u>                  | uires l<br>n sigr<br>uld be  | q pe         |   |   |  |  | 1 □ Ye                                   | s 2 □ No 3 🛣                                 | Probably 4 🗌 Unknown                     |
| orc                        | w req  | plet         |   |   |  |  | 24a. Was an                              |  | autopsy findings available               |
| 3ec                        | The la   | Completed    |   |   |  |  | autopsy<br>perform<br>1 \(\sum \) Yes 2  | ed? death                                    | completion of cause of<br>es 2 \sum No   |
| a                          | ilan: T  | Be C         | 25. Was case referred to medical examiner?  |   | 26. Place  | of Death (Check                        |  | A NO   | 65 2 110                                 |
| ₹                          | hysic<br>his ce<br>al dire   | 은            | 1 ☐ Yes 2 🕅 No Hospital: 1 ☐ In   | patient 2 K ER/Cutpatier                                  |  | 4  Nursing Ho                          | me 5 🗌 Resider                           | nce 6 Cther (Spe                             | ecify)                                   |
| اه ر                       | ling P   | ate:         | Tallatara 5 - 1 Griding   | injury 28b. Time of injury injury                         | work?  |  | 28d. Describe hov                        | v injury occurred                            |  |
| Division of Vital Records, | death<br>death<br>ctor: /  | Certificate: | 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be   | Injury - At home, farm, str                               | 2011 2011  | 2 □ No                                 | 205 Lti /Dt                              |  | hard Danie Marie                         |
| <u>Š</u>                   | l or A<br>after<br>Direction b   |              | 4 Homicide determined 28e. Place of building  | , etc. (Specify)  | eet, ractory, office                                     |  | City or Town,                            | eet and Number or R<br>State)                | urai Route Number,                       |
|                            | ospita<br>hours<br>ineral<br>ly fille  | Medical      | 29a. Certifier 1 Certifying Physician: To the bes   | t of my knowledge, death                                  | occurred at the time, da                                 | ate and place, ar                      | nd due to the caus                       | se(s) and manner as                          | stated.                                  |
|                            | he Ho<br>iin 24<br>he Fu<br>iplete   | Mec          | (Check 2 Medical Examiner: On the basis only one) 3 Certifying Nurse Practitioner: T                              | of examination and/or investored the best of my knowledge | tigation, in my opinion, d<br>, death occurred at the ti | death occurred at<br>ime, date and pla | the time, date and<br>ce, and due to the | place, and due to the<br>cause(s) and manner | e cause(s) and manner stated. as stated. |
|                            | Vith vith Con Con  |              | 29b. Signature and title of certifier   |   | 29c. License nu  |  |  | d. Date signed (Mor                          |  |
|                            | 2776.  |              | a soully  |   | 1073.  | 353                                    |  | 04.24  | - 2012                                   |
| (                          | 1 a  |              | 30. Name and address of person who completed cause  | of death (Item 23a) (Type, F                              | Print)   | <b>K</b> -                             | 1  |  | 1-2012<br>Id 21801                       |
|                            | Stat   | e            | 31. Date filed (Month, Day, Year) APR 25 2012   | istrar's Signature  | C. CHRENU  | L 04.                                  | JALISE                                   | sury, M                                      | 4 61801                                  |
|                            | Jiai   | ır           | APP 25 2012   | . 1 1   | 10 1   |  |  |  |  |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14763 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 04 Marie Eastwood 1035 Louise 2012 4a. Facility Name (if not institution, give street and number) 4c. County of Death

All Com I Co 4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs

10f. Zip Code

21804

1 Yes 2X No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Executive Secretary

SAL156414

Hours

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

8. Date of Birth (Month, Day, Year)

07/25/1922

9. Birthplace (State or Foreign

10d. Inside City Limits

1 X Yes 2 No

Missouri

Country)

10g. Citizen of What Country?

16b. Kind of Business/Industry

Race - American Indian, Black, White, etc.

White

USA

Bank

| Physician/ |
|------------|
| Medical    |
| Examiner   |
| Examiner   |

**Funeral** 

1 - State Registra

10a. State

Director

Funeral

Completed by

TENINSULA

Social Security Number

186-16-5539

Usual Residence of Dec

Maryland

11. Marital Status

10e. Street and Numbe

RIGIONAL

Wicomico

15. Decedent's Education

(Specify only highest grade completed)

10b. County

200 Civic Ave.

1 Never Married 2 Married

3 X Widowed 4 Divorced

Elementary/Secondary (0-12)

12

6. Sex

1 🗆 M 2 🗶 F

MODICAL

12. Was Decedent Ever in U.S.

1 Yes 2 No If Yes, Give

College (1-4 or 5+)

Armed Forces

Year or Dates

CENTE

10c. City, Town or Location

Salisbury

7. Age (In yrs. last birthday)

89

Director show be notified at 28a-f 10 23a ural", or items 23a I Examiner must b "natural", traumatic event, the Medical al Hygiene. Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other trainment.

death

Baltimore, Maryland 21215-0036

Physician/ Medical Examiner

sician and burial-transit Physician: The law requires that the death certificate be executed physician ast nse jo signed by the a page 2 s certificate has within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Hospital or Attending

Division of Vital Records, P.O. Box 68760

Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Laura Aiken Louis Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6162 Westbrooke Dr., Salisbury, MD 21801 Susan L. Patterson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/21/2012 Hanover Township, PA Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) mosm Due to (or as a consequence of): Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗀 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To only one) the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and t 068552 April 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

State

Date filed (Month, Day, Year)

APR 20 2012

Carroll

Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                                 |  |                          | For<br>State  |                                      | State of                                     | Maryla                      |                                       |                                 |                           |                     | and M        | lental Hy                      | /gien                    | е            |                            |  |          |
|---------------------------------|--|--------------------------|---|--------------------------------------|--|-----------------------------|---------------------------------------|---------------------------------|---------------------------|---------------------|--------------|--------------------------------|--------------------------|--------------|----------------------------|--|----------|
|                                 |  |                          | Registrar   |                                      |  |                             |                                       | Certifica                       | te of L                   | Death               |              |                                | Reg. N                   | 10. 2        | 112                        | 11.76                                      | L        |
| - 1                             | Physicia<br>Medic  |                          | 1. Decedent's Nam   |                                      | <sup>ast)</sup><br>lev Fos                   | ane.                        |                                       |                                 |                           |                     |              | 2. Date of De                  | eath                     | 46           | 2872                       | 9:15pm                                     | 1        |
|                                 | Examin   |                          | 4a. Racility Name (i  | f not Institution, air               | ve street and numb                           | per) [ ]                    | 1.1                                   | 4b Cit                          | y, Town or                | r Location          | of Death     |                                | 4                        | c. Count     | of Death                   |  | _        |
| and the same                    | <i>}</i>   |                          | CAST!   |                                      | PICEAT                                       | The                         | LAK                                   | 2                               | Alli                      | SDU                 | 114          |                                |                          | WI           | (0)                        | mico                                       |          |
|                                 | Funeral  |                          | 5. Social Security N  |                                      |  | 7. Age (In yrs.             | last birthe                           | day) If Und<br>Month            |                           | If Under<br>Hours   | Min.         | 8. Date of Bi<br>(Month, D     | rth<br>a <i>y, Year)</i> |              | 9. Birthp<br>Count         | lace (State or Foreign ry)                 |          |
|                                 | Director   |                          | 231-70<br>Usual Residence                                       |                                      | 1 <b>X</b> M 2 □ F                           | 60                          | Υ                                     | rs.                             |                           |                     |              | 10-6-                          | 195                      | 1            | VA                         |  |          |
|                                 | and<br>show  | ٥̈́                      | 10a. State  | 10b. County                          |  | 10c. C                      | City, Town                            | or Location                     |                           |                     |              |                                |                          |              |                            | Od. Inside City Limits                     | _        |
|                                 | //aryla<br>8a-f  | rect                     | MD  | Worces                               | ter  | Snc                         | ow H:                                 | i 1 1                           |                           |                     |              |                                |                          |              |                            | 1 XYes 2 ☐ No                              |          |
|                                 | the N  | ٥                        | 10e. Street and Nu  |                                      |  | 10110                       | , , , , , , , , , , , , , , , , , , , |                                 | Zip Code                  |                     |              |                                | 10g. C                   | Citizen of W | Vhat Count                 | try?                                       |          |
| . 7                             | s 23a  | Funeral Director         | 3829 M  | arket S                              | treet  |                             |                                       | 2                               | 1863                      |                     |              |                                | US                       | Α            |                            |  |          |
| 3                               | death<br>item  | Fur                      | 11. Marital Status  |                                      | 12. Was Deced                                | lent Ever in L              | J.S.                                  | 13. Was Dec                     | edent of Hi<br>ecify Cuba | ispanic Ori         | igin? (Spec  | cify Yes or No<br>Rican, etc.) | -                        |              | e - America<br>k, White, e |  |          |
| 18                              | s after<br>al", or   | d by                     | 1 ☐ Never Man<br>3 ☐ Widowed                                    | ried 2 X Married 4 Divorced          | Armed Ford  1 Yes  If Yes, Give  Year or Dat |                             | ļ                                     |                                 | 2 <b>X</b> No             |                     |              | , ,                            |                          | sBolina      |                            | iic.                                       |          |
| 100                             | 2 hour<br>"natur   | plete                    | (Spe  | 15. Decedent's ecify only highest of | Education                                    | -                           | 10                                    | ecedent's Us<br>Give kind of w  | ork done o                | ation               | st of workir | na                             | 16b.                     | Kind of Bu   | siness/Ind                 | lustry                                     |          |
| 70.215                          | S should be filed within 72 hours after death with the Manyland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at   | Completed                | Elementary/Sec  |                                      | College (1-4                                 | 4 or 5+)                    | - li                                  | fe. DO NOT u<br>intena          | se retired)               |                     |              | -9                             | Sn                       | inna         | kor                        | Motel                                      |          |
| 7 p                             | iled w<br>I Hyg<br>o <b>the</b>  | Be                       | 17. Father's Name   | (First, Middle, Last                 | )  |                             | 114.                                  | LIICCII                         |                           | 18. Moth            | er's Name    | (First, Middle                 |                          |              |                            | Moter                                      |          |
| $\mathcal{F}_{land}$            | d be f<br>denta<br>rrked<br>tic ev   | 욘                        | John B  | ailey                                |  |                             |                                       |                                 |                           | Rad                 | ie F         | osque                          |                          |              |                            |  |          |
| an A                            | should be filed wand Mental Hyg<br>7 is marked othe<br>raumatic event,   |                          | 19a. Informant's N  | ame/Relationship                     | (Type, Print)                                |                             | 19b. l                                | Mailing Addre                   | ss (Street a              | and Numb            | er or Rural  | Route Numb                     | er, City o               | or Town, St  | tate, Zip C                | ode)                                       | 7        |
| Σ                               | and 2 s<br>Health s<br>tem 27  |                          |   | Fosque                               | /Wife  |                             | 382                                   | 29 Mai                          | rket                      | st,                 | Sno          | w Hil                          | 1,                       | MD 2         | 1863                       | 3  |          |
| ore                             | e 1 and 2<br>t of Healt<br>If item 2<br>or other   |                          | 20a. Method of Dis  |                                      | ☐ Removal from S                             | 20b.                        | Place of C                            | Disposition (Na<br>crematory or | ame of<br>other plac      | e)                  | D            | ate                            | 20c. l                   | Location -   | City or Tov                | wn, State                                  |          |
| Ę:                              | t. Page<br>tment o<br>tant: If<br>jury or  |                          | 4 Donation  | 5 Other (Spec                        | cify)  |                             | rst                                   | Bapt                            | Cem                       |                     | 4-22         | -2012                          | Ma                       | ppsv         | ille                       | , VA                                       |          |
| Baltimore                       | permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.  |                          | 21 Signature of Hu  | ineral Service Lice                  | nsee   |                             |                                       | Benn:                           | ind Address               | s of Facili<br>nith | ty 917       | W. I<br>isbur                  | sab                      | ella         | St.                        |  |          |
|                                 |  |                          | 23a. Part 1. Enter  | the disease, or con                  | mplications that ca                          | used the dea                | ath. Do no                            | t enter the mo                  | de of dying               | dome<br>g, such as  | cardiac or   | respiratory a                  | rrest,                   | MD Z         | 1001                       | Approximate                                |          |
|                                 | Physician/   |                          | shock, or hea<br>Immediate Cause<br>disease or condition        | (Final                               | one cause on each                            | h line.                     | e'ic                                  |                                 | AN                        | CB                  | 0            | *                              |                          |              |                            | Interval Between<br>Onset and Death        |          |
|                                 | Medical<br>Examiner  |                          | resulting in death)   |                                      | a. Due to (o                                 | r as a consec               |                                       |                                 | 7/100                     |                     | /            |                                |                          |              | $\dashv$                   |  | _        |
|                                 | Lammer   | Je.                      | Sequentially list co  | onditions,                           | b. —   |                             |                                       |                                 |                           |                     |              |                                |                          |              |                            |  |          |
|                                 | ed<br>Isit   | edical Examiner          | if any, leading to in<br>cause. Enter once<br>Cause (Disease or | nmediate                             | Due to (o                                    | r as a consec               | quence of)                            | :                               |                           |                     |              |                                |                          |              |                            |  |          |
|                                 | cate be executed<br>physician and<br>s the burial-transit  | Еха                      | that initiated event<br>resulting in death)                     | ts 🔳                                 | c. Due to (o                                 | r as a consec               | quence of)                            |                                 |                           |                     |              |                                |                          |              | _                          |  | _        |
| 0                               | s be e<br>/siciar<br>e buri  | ical                     |   |                                      | ■ d.   |                             |                                       |                                 |                           |                     |              |                                |                          |              |                            |  |          |
| 3760                            |  |                          | IE EELAAL E   |                                      | _ u  |                             |                                       | -                               |                           |                     |              |                                | 1                        |              |                            |  | _        |
| 89<br>×                         | endin<br>r use   | an/l                     | IF FEMALE:<br>23b. Was decedent<br>in the past 12               |                                      | 23c. If yes, outco                           | ome of pregr<br>irth 2 🗌 Fe | nancy<br>tal death                    | 3 🗆 Ectopia                     | c pregnanc                | :v                  |              |                                |                          | 23d. Date    | e of deliver               | y  |          |
| Вох                             | e deatl<br>the att   | ysici                    | 1 Yes 2 Dunknown  | No                                   |  | ant at time of              |                                       | 5 Other (                       |                           |                     |              |                                |                          | Mon          | nth [                      | Day Year                                   |          |
| 0.                              | at the<br>ed by<br>detac   | / Ph                     | Part II. Other signi  |                                      | contributing to dea                          | ath but not re              | esulting in                           | the underlying                  | g cause giv               | en in Part          | l.           | 23e, Did t                     | obacco                   | use contrib  | bute to the                | e cause of death?                          |          |
| Division of Vital Records, P.O. | Hospital or Attending Physician: The law requires that the death certific: 24 hours after death.  Funeral Director: After this certificate has been signed by the attending parterly filled in by the funeral director, page 2 should be detached for use as | Completed by Physician/M |   |                                      |  |                             |                                       |                                 |                           |                     |              | 1 🗆                            | Yes 2                    | 2 □ No :     | 3 🗌 Proba                  | ably 4 Honknown                            |          |
| COL                             | aw rec<br>as bee<br>2 sho  | plet                     |   |                                      |  | _                           |                                       |                                 |                           |                     |              | 24a. Was<br>auto               |                          | ld bi        | rior to com                | sy findings available apletion of cause of |          |
| Ř                               | The lacate h   | Con                      |   |                                      |  |                             |                                       |                                 |                           |                     |              |                                | Speumo                   | de           | eath?                      | Rio  |          |
| ta                              | ician:<br>certifi  | œ                        | 25. Was case referr examiner?                                   |                                      | Hospital:                                    |                             |                                       |                                 | 26. Pla                   |                     | th (Check    | only one)                      |                          |              |                            | A4   | _        |
| Ž                               | Phys<br>this<br>ral di   | <u>و</u>                 | 1 ☐ Yes 2 ☐<br>27. Manner of Deat                               | ·                                    | 1  |                             | ER/Outp                               | atient 3 🗆 I                    | 28c. Injury               | 4 L. N              |              | ne 5 Resi                      |                          |              |                            | HOSPIGA                                    | $\dashv$ |
| o u                             | nding<br>tth.<br>: After<br>e fune   | cate                     | 1 Natural<br>2 Accident   | 5 Pending<br>Investigation           | (Month                                       | , Day, Year)                | inju                                  |                                 | work'                     |                     |              | 8d. Describe I                 | now inju                 | ry occurred  | a                          |  |          |
| isic                            | er des<br>ector<br>by th   | Certificate:             | 3  Suicide<br>4  Homicide                                       | 6 Could not determined               | be 28e. Place o                              |                             |                                       | , street, facto                 | ry, office                |                     | 2            | 8f. Location (                 | Street ar                | nd Number    | r or Rural F               | Route Number,                              |          |
| Ο̈́                             | urs after ral Dir  | a<br>C                   |   |                                      | 1  | g, etc. (Specia             |                                       |                                 |                           |                     |              | City or Tov                    |                          |              |                            |  |          |
|                                 | To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.  | Medical                  | (Check 2  | Medical Exar                         | ysician: To the besinner: On the basis       | of examination              | on and/or i                           | nvestigation, in                | n my opinio               | n, death o          | ccurred at t | he time, date a                | and place                | e, and due   | to the caus                | se(s) and manner stated                    | d.       |
| _                               | To th<br>To th   |                          | 29b. Signature and  | of certifier                         |  |                             |                                       | 29                              | c. License                |                     |              |                                | 29d. Da                  | ate signed   | (Month, Da                 | ay, Year)                                  |          |
|                                 |  |                          |   | 5                                    |  |                             |                                       |                                 | y) C                      | 058                 | 410          |                                | C                        | 14/1         | 7/1                        |  |          |
| -                               | 316  |                          | 30. Name and addr   | ess of person who                    | completed cause                              | of death (Iter              | m 23a) (Ty                            | pe, Print)                      | 173                       | )                   | SAC          | Y ALL                          | RI                       | nek          | 2.2                        | 1802                                       |          |
| 6                               | Stat   | ٠,                       | 31. Date filed (Mont  |                                      | 32. Reg                                      | gistrar's Signa             | ature                                 | harke                           | /                         |                     |              |                                | 7                        | - 1          |                            |  |          |
|                                 | Registra   | ir                       | A   | PR 20 2                              | 112 /  | wa .                        | P. 17                                 | 7                               |                           |                     |              |                                |                          |              |                            |  |          |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2012 Physician/ Month Frederick F. Frissell, Jr. 5:57 рМ . Medical April 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Min Hours **Director** 579-20-2177 1 🛛 M 2 🗆 F 87 Usual Residence of Decedent Feb. 25, 1925 Washington, DC 28a-f shov within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 XNo MD Wheaton Montgomery 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 12706 Littleton Street 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 X Married XX Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates. 1943-45 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene, is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Procurement Officer 12 Federal Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick F. Frissell, Sr. Marie W. Jouvenal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health as
Important: If item 27 is
any injury or other trat
once, Frederick F. Frissell, III/Son 102 Tapawingo Road, SE, Vienna, VA 22180 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State April 24, 4 Donation 5 Other (Specify) Metropolitan Crematory 2012 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W. Silver Spring. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Aspiration Pnuemonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Stroke Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or injury Due to (cir as a consequence on) and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Month Dav Pregnant at time of death Year the Unknown 9 I Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial Fibrillation, Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No Yes 2 X No 1 Yes Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 X No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pendina injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 231

Registrar DHMH 17 Rev 06-2011

State

Atul Rohatgi,

31. Date filed (Mo

MD

5

1+

8600 Old Georgetown Road, Bethesda, MD 20814

ess of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

2017,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Stephen E. Grant Apri] 2012 5:50 Medical 4a. Facility Name (if not institution, give street and number)
432 Blossom Tree Drive Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Social Security Number 1 Year | If Under 24 Hrs Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 120-20-9088 Days Country) **Director** 83 1 **X** M 2 □ F Dec. 12, 1928 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland notified Anne Arundel Annapolis 28a-f 1 Yes 2 No 10f. Zip Code ō 10g. Citizen of What Country? must be 23a Funeral 432 Blossom Tree Drive 21409 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? or þ Black, White, etc. 1 Never Married 2 Married White res, Give Year or Dates. 1951–72 1 Yes 2XXNo Specify "natural" Specify Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) alth and Mental Hygiene. 27 is marked other than r traumatic event, the M than Elementary/Secondary (0-12) 12 College (1-4 or 5+) Supervisor U.S. Naval Academy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth A. Grant မ Bessie Smith 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, nt of Health a t: If item 27 is or other trai Genevieve Grant/wife 432 Blossom Tree Drive Annapolis, Maryland 21409 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date Department of Important: If any injury or Baltimore Crematory 4/25/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 21 Signatu eral Se 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death . Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury DISCOURSE REPORTED THE PROPERTY. and that initiated events resulting in death) Last Due to (or as a consequence of) the burialattending physician for use as the buria Physician/Medical death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown be detached Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has perform Yes 1 Yes

Baltimore, Maryland 21215-0036 Box 68760 Division of Vital Records, P.O. certificate 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 5 Residence 6 Other (Specify) funeral ( s after death. I Director: After the 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural Accident To the Hospital or Attending 5 Pending iniury 1 Yes 2 No М Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying N Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year, 31. Date filed (Mo State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Edith F. Goodman 0135 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Salisbury Rehabilitation + Nursing Ctr isbury 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs **Funeral** 1 □ M 2**X** F Months Hours New York 083-05-7370 10/31/1916 95 **Director** Usual Residence of Decedent f Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 🗌 Yes 2 🕱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 200 Civic Ave. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White 3 ₭ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within 12 Owner Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Jacob Fradkin Rose Fradkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth G. Zeidman/Daughter 1504 Lavale Terrace, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite cemetery, crematory or other place) injury or 1 X Burial 2 Cremation 3 Removal from State Pinelawn 4 Donation 5 Other (Specify) Wellwood Cemetery 4/22/2012 Long Island, NY Signature of Funeral Service Licenses Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown g Unknow Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۶ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 autopsy perform certificate has 25. Was case referred to medical Division of Vital director. 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA this s after death.

I Director: After this id in by the funeral d 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injurv work? 5 Pending 1 Natural M 2 🗆 No Accident Investigation 6 Could not be 3 Suicide within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifies 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signat 29d. Date signed (Month. Day. Year) 4

Registrar

State

31. Date filed (Month, Day,

DHMH 17 Bev 7/2009

vic Ave. Salisbury, MD

ho completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2 Date of Death Month Day Physician/ ам 21 2012 3:37 W. Gigioli, April George Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Medstar Montgomery Medical Ctr. 01ney If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 140-26-6397 Director 1 🖾 M 2 🗆 F 77 May 6, 1934 NJ Usual Residence of Dec 28a-f show 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits aţ with the Maryland Director Examiner must be notified 1 Yes 2 X No MD Worcester Berlin 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 21811 USA ll Brandywine Drive death v "natural", or items 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 XYes 2 No þ 1 Never Married 2 Married 72 hours after Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Vietnam 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Engineer traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked of ၉ Ida Massi Antonio Gigioli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 11 Brandywine Drive, Berlin, MD 21811 Elizabeth G. Gigioli/Wife 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date April 25 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Gate of Heaven Cemetery Silver Spring, MD 4 Donation 5 Other (Specify) 2012 Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Signature of Funeral Service Licenses 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Plu i i n disease or condition Medical resulting in death) Due to (or **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying nei Due to (or as a consequence of) Exami that the death certificate be executed Cause (Disease or Injury that initiated events resulting in death) Last trar and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Year Pregnant at time of death signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed Yes 2 has page 2 certificate the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 A/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural Accident 5 Pending work?
1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11. I Propose Ph. I., A. Olay 20832

State Registrar

11

32

2 5

|   |                  | Please 1  | ype or Pri  | nt in l             | Black I                        | ndelible In  | k. Ensure A                    | All Copie                             | s Are                         | Legible                 | е.   |
|---|------------------|---|---|---------------------|--------------------------------|--|--------------------------------|---------------------------------------|-------------------------------|-------------------------|--|
|   |                  | For State   | State of M  | arylan              |                                |  | Health and N                   | /lental Hy                            | /giene                        | 001                     | 0 1176   |
|   |                  | Registrar  1. Decedent's Name (First, Middle, Last)   |   |                     | Ce                             | rtificate of I   | Death                          | 2. Date of De                         | Reg. No.                      | 201                     | 2 4/6  |
| Physicia<br>Medic   |                  | Elbert  | Quentin   | Gr                  | ossnic                         |  |                                | April                                 | 1 <sup>1</sup> 9 <sup>y</sup> | Ž0"                     | 3. Time of Death 10:35 p.M                         |
| Examin  | er               | 4a. Facility Name (if not institution, give st<br>10504 Harmony Road                                |   |                     |                                | 4b. City, Town, o                                      | or Location of Death<br>ville  |                                       |                               | County of De<br>Freder: |  |
| Funeral<br>Director   |                  | 5. Social Security Number 6. Sex 219-36-4339  | M 2 □ F 7. A9   | e (In yrs. la<br>93 | as <i>t birthd</i> ay)<br>Yrs. | If Under 1 Year<br>Months Days                         | If Under 24 Hrs.<br>Hours Min. | 8. Date of Bir<br>(Month, Da<br>Feb 1 | rth<br>av, Year)<br>19        | 9. B<br>19 Ma           | irthplace (State or Foreign<br>country)<br>ry Land |
| nd<br>now<br>at   | L.               | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City           | y, Town or Lo                  | ocation  | <u>'</u>                       |                                       |                               |                         | 10d. Inside City Limits                            |
| Λarylar<br>:8a-f sl<br>tified (   | Funeral Director | Maryland Frederic   | k   |                     | yersvi                         |  |                                |                                       |                               |                         | 1 Yes 2 No   |
| th the I  | al Di            | 10e. Street and Number  |   |                     |                                | 10f. Zip Code  |                                |                                       | 10g. Citi                     | zen of What (           | Country?   |
| ath wi  | uner             | 10504 Harmony Road  | 1<br>2. Was Decedent E                                    | ver in II 9         | 113                            | 21773  | lispanic Origin? (Spe          | oify Ves or No-                       |                               | USA                     | i b- di  |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.                                  | ğ                | 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced  | Armed Forces?  1 Yes 2 X  If Yes, Give  Year or Dates.    |                     |                                |  | an, Mexican, Puerto            |                                       |                               | Black, Wh               |  |
| 72 hou<br>n "nate<br>ledica   | Completed        | 15. Decedent's Edu<br>(Specify only highest grade   |   |                     | (Give                          |  | during most of work            | ing                                   | 16b. Kir                      | nd of Busines           | s Industry   |
| within<br>giene.<br>er thar   |                  | Elementary/Seconday (0-12)  | College (1-4 or 5   | i+)                 |                                | no NOT use retired)                                    |                                |                                       | Ins                           | urance                  | Agency   |
| e filed<br>Ital Hy<br>ed oth<br>event   | To Be            | 17. Father's Name (First, Middle, Last)   |   |                     |                                |  | 18. Mother's Nam               |                                       |                               | ,                       |  |
| ould b<br>nd Mer<br>mark  |                  | Charles Elbert  19a. Informant's Name/Relationship (Type  | Grossnic  | кте                 | 10b Maili                      | ng Address (Street                                     | Sallie and Number or Rura      |                                       |                               | therma                  |  |
| d 2 sh<br>alth ar<br>n 27 is<br>er trau   |                  | Lana Stottlemyer/d  | . ,   |                     |                                | -  | fe Road,                       |                                       |                               |                         | •  |
| Page 1 an<br>nent of He<br>ant: If iten<br>ury or oth   |                  | 20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)        | emoval from State   | 1 0                 | emetery, crei                  | osition (Name of<br>matory or other place<br>le Breth: | ren Apr.2                      | Date 3,2012                           | ı                             | •                       | or Town, State<br>le, Maryland                     |
| permit. Departr Import any inj  |                  | 21. Signature of Lyneral Service House  |   | •                   | - 1                            | 2. Name and Addre                                      | ss of Facility Funeral H       |                                       |                               | n Stre                  |  |
| -   |                  | 23a. Part 1. En the disease, or complic shock, or heart failure. List only one                      |   |                     |                                |  |                                |                                       |                               | Lie, M                  | Approximate  |
| Physician/<br>_ Medical   |                  | Immediate Cause (Final disease or condition resulting in death)                                     | Due to (or as a   | Arri                | th m                           | nia  |                                |                                       |                               |                         | Interval Between<br>Onset and Death                |
| Examiner  | iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying                  | Due to (or as a   | a consequ           | ence of);                      |  |                                |                                       |                               |                         |  |
| ecuted<br>and<br>-transit   | al Examine       | Cause (Disease or impury that initiated events c. resulting in death) Last                          | Due to (or as a   | consequ             | ence of).                      |  |                                |                                       |                               |                         | 1  |
| icate be executed<br>g physician and<br>is the burial-transit   | edical E         | d.  |   |                     |                                |  |                                |                                       |                               | <del>.</del>            |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Medic  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown             | c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown | 2 🗌 Feta            | death 3                        | ☐ Ectopic pregnand ☐ Other (specify)                   | су                             |                                       | 2                             | 3d. Date of d<br>Month  | elivery<br>Day Year                                |
| res that the signed by  | d by Pł          | Part II. Other significant conditions conf  | ributing to death b                                       | ut not resi         | ulting in the u                | underlying cause gi                                    | ven in Part I.                 |                                       |                               |                         | to the cause of death?                             |
| w requ  | Completed by     |   |   |                     |                                |  |                                | 24a. Was                              |                               |                         | utopsy findings available                          |
| Physician: The law i<br>r this certificate has b<br>sral director, page 2 s   | Com              |   |   |                     |                                |  |                                |                                       | psy<br>ormed?<br>2 🛣 No       | death?                  | completion of cause of                             |
| ician:<br>certific<br>ector,  | Be               | 25. Was case referred to medical examiner?  | spital:   |                     |                                |  | ace of Death (Check            | ( only one)                           |                               |                         |  |
| Physical this carral direction  | 2                | 1 ☐ Yes 2 ☒ No ☐ Ho   | 1 Inpatie   |                     | ER/Outpatie                    | nt 3 DOA Oth   | 4 L Nursing Ho                 | me 5 K Residence 128d. Describe 1     |                               |                         | cify)  |
| anding<br>sath.<br>rr: Afte   | ficate           | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation  | (Month, Day   | ( Year)             | injury                         | work   |                                | Eod. Describe i                       | iow injury                    | occurred                |  |
| tal or Atter rs after de al Directo   | d Certificate:   | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined  | 28e. Place of Inju<br>building, etc                       |                     |                                | eet, factory, office                                   | 31                             | 28f. Location (\$<br>City or Tov      |                               | Number or R             | ural Route Number,                                 |
| he Hospii<br>in 24 hou<br>he Funer:<br>ipleted fill   | Medical          | 29a. Certifier (Check only one) Certifying Physic Medical Examine (Check only one) Certifying Nurse | r: On the basis of e                                      | kamination          | and/or inves                   | tigation, in my opinic                                 | on, death occurred at          | the time, date a                      | and place, a                  | and due to the          | cause(s) and manner stated.                        |
| Nith<br>With<br>To t  |                  | 29b. Signature and title of certifler   |   |                     |                                | 29c. License   | e number                       |                                       |                               | signed (Mon             |  |
| 10  |                  | 30. Name and address of person who con  |   |                     | 23a) (Type, F                  |  | e Ct. A                        | n yers vi                             | ide                           | MD :                    | 11773  |
| Stat<br>Registra  |                  | 31. Date filed (Month, Day, Year) APR 2 3 201   | 32. Registra  | r's Signati         | ure A                          | arkel  | 7                              |                                       |                               | -                       |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0944 25/2012 00:30 A Physician/ Charles Dean Hall, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Harford **Examiner** 1332 Hall Road Havre de Grace Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min 0470771930 220-24-5097 Maryland **Director** 1 🌠 M 2 🗆 F 82 Yrs Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Harford 1 X Yes 2 No Havre de Grace Maryland 10e. Street and Number 10f. Zip Code 9 United States of must be r 21078 Funeral 1332 Hall Road an "natural", or items Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. by 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Year or Dates. Korea Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3

Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ગe filed wn. \*શ Hygiene. `વr than "r (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumating. the Civil Service Gunner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hurley Hall Flossie Caldwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21078 1332 Hall Rd., Havre de Grace, Maryland Randall Hall (son) 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State Havre de Grace, 1X Burial 2 Cremation 3 Removal from State Angel Hill Cemetery04/28/2012 4 ☐ Donation 5 ☐ Other (Specify) Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. Washington St. Havre de Grace, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physicsan/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): the burial-transit and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Pregnant at time of death ate has been signed by the a page 2 should be detached 1 ☐ Yes 2 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🔀 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has 1 Yes 2 No \_ Yes Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ္ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident death. 1 Yes 2 No after death Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Dav. Year) 47804 04/26/6012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MINDWIEL 16 Alberdeen Rune Alberten 31. Date filed (Month, Da

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ <sup>D</sup>2012 Margaret M. Hyland April 19. 10:40 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's HeartFields Assisted Living Bowie Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Months Hours Min. (Month, Day, Year) **Director** 205-10-9418 94 1 M 2 X F Yrs 1917 Pennsylvania 1, Usual Residence of Decedent rms 23a or 28a-f show must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Bowie 1XXYes 2 No MD Prince George's 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 7600 Laurel-Bowie Rd. 20715 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian 1 and 2 should be filed within 72 hours after deal of Health and Mental Hygiene. item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elizabeth Long Ralph Bensing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health a tant: If item 27 is Paul Hyland / Son 628 Wayward Dr., Annapolis, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1XXBurial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven Cem. 4/25/2012 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Juneral Service ice is 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland 20715 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, shock, or heart failure. List Approximate Interval Between Immediate Cause (Final Onset and Death Physician) disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death ed by the a detached f 1 ☐ Yes 2 ☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? certificate has performe 1 Yes Yes -2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No tsules 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: hours after death. Ineral Director: After Natural 5 Pending М Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours To the Funeral Medical 29a. Certifier Lecritifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examine 3 ☐ Certifying Nurse n the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ctitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

|                            |  |                  | For State   |                            | State of Ma   | aryland               |                     |   |              | and M             | lental Hy                      | giene           | 0.0                               |                           |                          |                       |
|----------------------------|--|------------------|---|----------------------------|---|-----------------------|---------------------|---|--------------|-------------------|--------------------------------|-----------------|-----------------------------------|---------------------------|--------------------------|-----------------------|
|                            |  |                  | Registrar  1. Decedent's Name (First, A                                       | Middle, La:                | st)   |                       | Cei                 | rtificate of                            | Deatn        |                   | 2. Date of De                  | Reg. No         | 0. 20                             | 12                        | C. Time                  | 4/1                   |
|                            | Physicia<br>Medic  |                  | Elwood Lyle   |                            | •   |                       |                     |   |              |                   | Month                          |                 | ay 2012                           | ar                        | 3. Time 4:06             | of Death<br>PM        |
| inch                       | Examir   |                  | 4a. Facility Name (if not institu   |                            |   |                       |                     | 4b. City, Town, c                       | r Location   | of Death          | *• P = -                       | 40              | c. County of D                    | eath                      |                          |                       |
| April 1                    |  |                  | Bowie Health 5. Social Security Number  | Cen                        |   | - //- um lont         | to both along       | Bowie If Under 1 Year                   | T iž I Indoi | 0.4 Шее           | 2 = 4 - 6 PM                   | _               | cince G                           |                           |                          |                       |
|                            | Funeral Director   |                  | 220-28-5815   |                            | ·   | e (In yrs. last<br>79 | t birthday)<br>Yrs. | Months Days                             | Hours Hours  | r 24 Hrs.<br>Min. | 8. Date of Bir<br>(Month, Da   |                 | 9.                                | Birthpl<br>Co <i>untr</i> | ace (State<br>y)         | or Foreign            |
| No.                        | *  |                  | Usual Residence of Deced  | ent                        |   |                       |                     |   |              |                   | Oct. 2                         | 4, 1            | 1932 Ma                           | ry1                       | and                      |                       |
|                            | ryland<br>-f sho<br>ied at   | cto              | 10a. State 10b. Co  | ,                          | o   | 10c. City, 7          |                     |   |              |                   |                                |                 |                                   | 10                        |                          | Oity Limits           |
|                            | r 28a<br>notifi  | Dire             | MD Pri  | nce (                      | George's  | Mitc                  | hellv               | 111e                                    |              |                   |                                | 10.0            |                                   |                           |                          | es 2 <sup>X</sup> No  |
|                            | with th  | iral             | 2000 Mitchel  | 11vi1                      | le Rd.  |                       |                     | 20716                                   |              |                   |                                | 10g. Ci         | itizen of What<br>Σ Δ             | Count                     | y?                       |                       |
|                            | filed within 72 hours after death with the Maryland al Hygiene.<br>al Hygiene.<br>d other than "natural", or items 23a or 28a-f show went, the Medical Examiner must be notified at  | Funeral Director | 11. Marital Status  |                            | 12. Was Decedent E                                  | ver in U.S.           | 13. \               | Nas Decedent of F                       | lispanic Or  | igin? (Spe        | cify Yes or No-                |                 | 14. Race - A                      | nerica                    | n Indian,                |                       |
| 36                         | after o  |                  | 1 Never Married 2   |                            | Armed Forces?  1  Yes 2  If Yes, Give               |                       | st                  | f Yes, specify Cub                      |              |                   | Rican, etc.)                   |                 | Black, W                          |                           |                          |                       |
| 21215-0036                 | atura<br>cal Ex  | Completed by     | 3 Widowed 4 Dive  | orced<br>cedent's E        | Year or Dates.                                      | Gua                   | ra                  | dent's Usual Occup                      |              |                   | -                              | 101             |                                   | Whi                       |                          |                       |
| 215                        | n 72 h<br>e.<br>ian "n<br>Medi   | ldmo             | (Specify only<br>Elementary/Secondary (0.                                     | highest gra                | ade completed)  College (1-4 or 5                   |                       | (Give i             | kind of work done<br>O NOT use retired) | during mos   | st of workir      | ng                             | 16b. K          | Kind of Busine                    | ss/Indu                   | istry                    |                       |
| 21                         | iled within<br>I Hygiene.<br>other thai<br>rent, the N   |                  | 9   |                            | Oblicge (1 4 0) 5                                   |                       |                     | Truck Dr                                | iver         |                   |                                | Ind             | lependa                           | nt                        | Driv                     | er                    |
| Maryland                   | ntal Hyg<br>ed othe<br>event,  | To Be            | 17. Father's Name (First, Mid<br>Alexander J                                  |                            |   |                       |                     |   |              |                   | (First, Middle,                | Maiden          | Surname)                          |                           |                          |                       |
| ary!                       | l 2 should be file<br>lith and Mental I<br>27 is marked o<br>r traumatic eve   | ľ                | 19a. Informant's Name/Rela  |                            |   |                       | 10h Mailie          | ng Address (Street                      |              |                   | Hagan                          | - 01            | - T Ot-1                          | 7: 0                      | 4.1                      |                       |
|                            | and 2 sh<br>Health ar<br>tem 27 is   |                  | Ella M. Harme   |                            |   |                       |                     | Mitchell.                               |              |                   |                                |                 | ville.                            |                           |                          | 716                   |
| ore,                       | of Healt<br>of Healt<br>if item 2  |                  | 20a. Method of Disposition<br>1 🕱 Burial 2 🗌 Crema                            | ation 2 C                  | D   | 20b. Plac             | ce of Dispo         | sition (Name of<br>natory or other plac | - :          |                   | ate                            | 20c. L          | ocation - City                    | or Tow                    | n, State                 |                       |
| Baltimore,                 | Page 1<br>tment of<br>tant: If it<br>jury or o   |                  | 4 Donation 5 Ot   | her (Specif                | ý)  |                       | •                   | oln Ceme                                |              | 4/23/             | 2012                           | Bre             | entwood                           | , M                       | D                        |                       |
| Bal                        | permit. Page 1: Department of I Important: If it any injury or of  |                  | 21. Signature of Emperal Serv   | vice Liby s                | ee  |                       |                     | . Name and Addre                        |              |                   | all Fu                         |                 |                                   |                           |                          |                       |
|                            |  | Н                | 222 Part 1. Enter the dicease   | se, or com                 | plications that ca ed                               | the death. [          |                     | 512 NW C:<br>er the mode of dyin        |              |                   |                                | -               | 2071                              |                           | Approxima                | ate                   |
|                            | Physician  | 9 18             | shock, or heart failu. Immediate Cause (Final disease or condition            | List only or               |   |                       | anarv               | Syndrome                                |              |                   |                                |                 |                                   |                           | nterval Be<br>Onset and  | etween                |
|                            | Medical<br>Examiner  |                  | resulting in death)   |                            | a. Due to (or as a                                  |                       |                     | Dynar onk                               |              |                   |                                |                 |                                   |                           |                          |                       |
|                            | LAGITIMIO  | er               | Sequentially list conditions,   |                            | D   | etes N                |                     | tus                                     |              |                   |                                |                 |                                   | 4                         |                          |                       |
|                            | ted<br>Insit   | Examiner         | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | <                          | Due to (or as a                                     | a consequen           | ce or):             |   |              |                   |                                |                 |                                   |                           |                          |                       |
|                            | execuran and rial-tra  |                  | that initiated events<br>resulting in death) Last                             |                            | Due to (or as a                                     | consequen             | ce of):             |   |              |                   |                                |                 |                                   | +                         |                          |                       |
| 200                        | cate be executed<br>physician and<br>s the burial-transit  | edical           |   |                            | d   |                       |                     |   |              |                   | _                              |                 |                                   | $\perp$                   |                          |                       |
|                            |  |                  | IF FEMALE:  |                            | 23c. If yes, outcome of                             | of preamans           | ,                   |   |              |                   |                                |                 |                                   |                           |                          |                       |
| Box                        | attendatter  | cian             | 23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No             | 1                          | 1 Live Birth 2                                      | 2 🗌 Fetal de          | eath 3 🗆            | Ectopic pregnand Other (specify)        | у            |                   |                                | ĺ               | 23d. Date of o<br>Month           |                           | /<br>ay                  | Year                  |
| O. B                       | the de<br>by the<br>ached  | Physician/M      | 9 Unknown   |                            | 9 🗌 Unknown   |                       |                     |   |              |                   |                                |                 |                                   |                           |                          |                       |
| P.O.                       | s that<br>gned b   | by               | Part II. Other significant cor<br>Hypertens                                   |                            | ontributing to death bu                             | ut not resulti        | ng in the u         | nderlying cause giv                     | en in Part   | I.                |                                |                 | use contribute                    |                           |                          |                       |
| rds                        | requires that the death certifical<br>been signed by the attending p<br>should be detached for use as  | Completed        |   |                            |   | J C                   |                     | _                                       |              |                   |                                |                 | □ No 3 🕅                          |                           |                          |                       |
| oce                        | e law i<br>s has k   | ldmo             | Hyperchol   |                            | oid Antibo  | uy Syi                | IUT OIII            | е                                       |              |                   | 24a. Was autop                 |                 | 24b. Were a<br>prior t<br>death   | o com                     | y findings<br>oletion of | available<br>cause of |
| E<br>E                     | sician: The<br>certificate<br>rector, pag  |                  | 25. Was case referred to med  | _                          | . oreliira  |                       |                     | 26 PI                                   | ace of Dea   | th (Check         | 1 Yes                          |                 | o 1 🗆 Y                           | es 2                      | □ No                     |                       |
| Vita                       | Physicie<br>this cer   | To B             | examiner?<br>1 Yes 2 X No   |                            | Hospital:   | ent 2XIXIER           | /Outpatien          | Oth                                     | or:          |                   | ne 5 🗆 Resid                   | lence 6         | S C Other (Sp.                    | ecify)                    |                          |                       |
| Division of Vital Records, | To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a |                  | 27. Manner of Death<br>1X Natural 5 ☐ Pe                                      | endina                     | 28a. Date of injury<br>(Month, Day,                 |                       | b. Time of injury   | 28c. Injun<br>work                      |              |                   | 8d. Describe h                 |                 |                                   |                           |                          |                       |
| sior                       | I or Attending I after death. Director: After I in by the fune   | Certificate:     | 2 Accident In   | vestigation<br>ould not be |   | n. At hamo            | form atvo           | M 1 🗆                                   | Yes 2 .      | _                 | 06.1                           |                 |                                   |                           |                          |                       |
| )<br>į<br>Vi               | al or A<br>s after<br>I Direct   | Cer              | 4 ☐ Homicide de   | etermined                  | building, etc.                                      |                       | , iaim, sire        | et, ractory, office                     |              |                   | 8f. Location (S<br>City or Tow |                 |                                   | tural H                   | oute Num                 | ber,                  |
|                            | To the Hospital or within 24 hours afte To the Funeral Dir completely filled in  | Medical          | 29a. Certifier 1 Certification (Check 2 Medi                                  | fying Phys                 | sician: To the best of r<br>ner: On the basis of ex | my knowledg           | ge, death o         | ccurred at the time                     | e, date and  | place, and        | d due to the ca                | use(s) a        | nd manner as                      | stated                    |                          |                       |
|                            | thin 24<br>the F<br>the F<br>mplet   |                  | only one) 3 Certing 29b. Signature and title of certing 29b.                  | tying Nurs                 | e Practitioner: To the                              | best of my k          | nowledge,           | death occurred at t                     | he time, da  | te and plac       | e, and due to t                | ne cause        | e(s) and manner                   | as sta                    | ted.                     | anner stated.         |
|                            | <b>2</b> ≥ <b>2</b> ⊗  |                  | - / /   | / ) /                      | Verma   | . M.                  | 17.                 | 29c. License<br>D006                    |              |                   |                                |                 | te signed <i>(Mor</i><br>. 7/2012 | ith, Da                   | y, Year)                 |                       |
| Ų.                         |  |                  | 30. Name and address of per   |                            |   |                       |                     |   | 002          |                   |                                | <del>+</del> /1 | . / / 2012                        |                           |                          |                       |
| H.                         | 34   |                  | Perry Wiseman   | n, M.I                     | D., 15001   | Health                | n Cen               | ter Dr.,                                | Bowi         | e, MD             | 2071                           | 6               |                                   |                           |                          |                       |
|                            | Stat<br>Registra   | e<br>ir          | 31. Date filed (Month, Day, Ye  | 2 4 20                     | )12 32. Registrar                                   | r's Signature         | 1. 4                | are                                     |              |                   |                                |                 |                                   |                           |                          |                       |

| gierie   | 20 | 10 |   | 1   | -    | 7   | 7    |   |
|----------|----|----|---|-----|------|-----|------|---|
| Reg. No. | 20 | 14 |   |     | 4    | - [ | 1    | 4 |
| eath     |    |    | 2 | Tim | o of | Dog | · la |   |

|                     |   | •                | For State Registrar  | ate of Maryland  |                       | ırtment of F<br><i>tificate of E</i>                            |                                   |  | _                | 012 1477   |
|---------------------|---|------------------|--|--|-----------------------|---|-----------------------------------|--|------------------|--|
|                     | Physicia  |                  | 1. Decedent's Name (First, Middle, Last)  Lester W. Hilbert  |  |                       |   |                                   | 2. Date of Dea                           | ath              | 3. Time of Death<br>7:01 Р м   |
|                     | Medic<br>Examir   |                  | 4a. Facility Name (if not institution, give street<br>Regency Park Assiste   |  |                       | 4b. City, Town, or  | Location of De                    |  |                  | of Death<br>ne Arundel   |
|                     | Funeral<br>Director   |                  | 5. Social Security Number 6. Sex 176-05-2306   | 7. Age (In yrs. las  |                       | If Under 1 Year<br>Months Days                                  | If Under 24 H                     |  | h                | Birthplace (State or Foreign Country)  |
|                     | *   | b                | Usual Residence of Decedent  10a. State  10b. County   | 10c. City,   | Yrs. Town or Loc      |   |                                   | pair. 24                                 | , 1913           | Pennsylvania   |
|                     | ne Maryla<br>or 28a-f s<br>notified   | Direct           | Maryland Anne Arun  10e. Street and Number   | del  |                       | Gar<br>10f. Zip Code  | mbrills                           |  | 40.000           | 1  Yes 2 XX No   |
|                     | death with the Maryland<br>items 23a or 28a-f sho<br>ier must be notified at  | Funeral Director | 730 Rt. 3 South  |  |                       |   | 21054                             |  | 10g. Citizen of  | U.S.A.   |
| 9036                | dea<br>rite   | Completed by Fu  | 1 Never Married 2 Married 1  | as Decedent Ever in U.S.<br>med Forces?<br>□ Yes 2 <b>XX</b> No<br>Yes, Give<br>ar or Dates. | If                    | /as Decedent of Hi<br>Yes, specify Cuba<br>☐ Yes 2 <b>XX</b> No | n, Mexican, Pu                    | (Specify Yes or No-<br>erto Rican, etc.) |                  | ee - American Indian,<br>ck, White, etc.<br>:: White                                   |
| 215-(               | n 72 hou<br>e.<br>ian "nat<br>Medica  | mple             | 15. Decedent's Education (Specify only highest grade core Elementary/Secondary (0-12)  |  | (Give k               | ent's Usual Occupa<br>ind of work done of<br>NOT use retired)   | ation<br>Juring most of v         | vorking                                  | 16b. Kind of B   | usiness/Industry   |
| d 21                | s filed within 72 hour tal Hygiene.<br>d other than "natu event, the Medical  | Be Co            | 12. Father's Name (First, Middle, Last)  |  |                       | Manage  |                                   | Name <i>(First, Middle, I</i>            |                  | llar Tractor Co  |
| Maryland 21215-0036 | ould be fill<br>d Mental<br>marked o  | 오                | William F. Hilbert   |  |                       |   | Jenn                              | y A. Strai                               | usbaugh<br>———   |  |
|                     | ge 1 and 2 should be<br>the free to free the free to free the free to free the free transfer or other transfer to free free free free free free free fre  |                  | 19a. Informant's Name/Relationship (Type, Pri<br>Stephen Hilbert/son   | nt)  | 19b. Mailing<br>501 ] | g Address (Street a<br>First Sti                                |                                   | Rural Route Number<br>Annapolis          |                  |  |
| Baltimore,          | Page 1 anent of Fant. If ite  |                  | 20a. Method of Disposition  1XXBurial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)  | ral from State Cei   | metery, crem          | ition (Name of<br>atory or other place<br>Mem. Gar              | e)<br>Codenis 4                   | Date /26/2012                            |                  | City or Town, State  |
| Balti               | permit. Page 1 and 2<br>Department of Health<br>Important; if item 27<br>any injury or other tr   |                  | 21. Signature of Funeral Service Licensee  | alle   | 22.<br>14             | Name and Addres   | s of Facility Jo                  | ohn M. Tay                               | ylor Fur         | neral Home<br>olis, MD 21401   |
|                     | Physician/  |                  | 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Immediate Cause (Final disease or condition | ns that caused the death.  |                       |   | g, such as card                   |  |                  | Approximate Interval Between Onset and Death   |
| -                   | Medical Examiner  |                  |  | Due to ras conseque  | nce of):              | Des   | PUI-P                             |  |                  | 54841  |
| WI ST               | red   | ıminer           | cause. Enter Underlying<br>Cause (Disease or injury  | Due to (or as a conseque   | nce of):              |   |                                   | -  |                  |  |
| _                   | eath certificate be executed attending physician and I for use as the burial-transit  | edical Examiner  | that initiated events C. —   | Due to (or as a conseque   | nce of):              |   |                                   |  |                  |  |
| 68760               | rtificate k<br>ing physi<br>e as the  |                  | IF FEMALE:   |  |                       |   |                                   |  |                  |  |
| Box                 | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi | Physician/M      | in the past 12 months?   | ves, outcome of pregnance Live Birth 2 Fetal of Pregnant at time of de Unknown               | death 3               | Ectopic pregnance<br>Other (specify)                            | у                                 |  |                  | te of delivery<br>nth Day Year   |
| rds, P.O.           | v requires that the dea<br>been signed by the a<br>should be detached to  | Completed by P   | Part II. Other significant conditions contribut  | ng to death but not resul  | ting in the un        | derlying cause giv  | en in Part I.                     |  |                  | ribute to the cause of death?  |
| Records,            | sician: The law n<br>s certificate has b<br>Jirector, page 2 sl   | Comple           |  |  |                       | -,-   |                                   | 24a. Was a autops perfor                 | med?             | Nere autopsy findings available prior to completion of cause of death?  I ☐ Yes 2 ☐ No |
| of Vital            | ysician:<br>is certific<br>director,  | To Be            | 25. Was case referred to medical examiner? 1 \( \sum \) Yes 2 \( \sum \) No Hospita  | l:<br>1 ☐ Inpatient 2 ☐ E  | R/Outpatient          | Othe  | r: 4 \ Nursing                    | heck only one)                           | ence 6 define    | Specific Assistant   |
| on of               | nding Phath.<br>Ith.<br>After the funeral   | cate:            | 27. Manner eath 28.  1 latural 5 Pending 2 Accident Investigation  |  | 8b. Time of injury    | 28c. Injury<br>works  | at                                | 28d. Describe ho                         |                  | 7 7  |
| Division            | il or Attending Ph<br>after death.<br>Director: After thi<br>d in by the funeral  | Certificate:     | 3 Suicide 6 Could not be   | Place of Injury - At hom<br>building, etc. (Specify)   | e, farm, stree        | et, factory, office   |                                   | 28f. Location (St<br>City or Town        |                  | er or Rural Route Number,  |
|                     | To the Hospital of within 24 hours af To the Funeral Discompletely filled in  | Medical          | 29a. Certifier 1 Certifying Physician: (Check 2 Medical Examiner: On only one) 3 Certifying Nurse Practicular                            | o the best of my knowled<br>the basis of examination a                                       | and/or investic       | ation, in my opinior  | <ol> <li>death occurre</li> </ol> | d at the time, date an                   | d place, and due | to the cause(s) and manner stated  |
|                     | To th<br>withir<br>To th<br>comp  |                  | 29b. Signature and title of certifier  | lit in   | Kilowicogo, c         | 29c. License  |                                   |  |                  | Month, Day, Year)  |
| $\alpha$            | Mo.   |                  | 30. Name and address of person who complet   | ed cause of death (Item 2  | 3a) (Type, Pri        | int) Mud  | ion 1                             | ark Dri                                  | ve Cle           | Berne 200  |
|                     | Stat<br>Registra  | _                | 31. Date filed (Month PR 2 4 2012  | 32. Fegistrar's Signatur   | 4. pa                 | whi   | - /-                              |  | (                | 7 - 1  |

Registrar DHMH 17 Rev 06-2011

|  |                            | I LINE B—C PER I<br>1 - State<br>Registrar  | The Garage of M   | aryland / I  | ck Indel<br>Departm<br><i>Certific</i>  |  | Health and  | Mental H   | ygien<br>Reg. N  | e 2n  | 12 147  |
|--|----------------------------|---|---|--|---|--|---|--|--|---|---|
| Physicia<br>Medic  |                            | 1. Decedent's Name (First, Middle Virginia R  | ith Hayes   |  |   |  |   | 2. Date of D   | eath   |   | 3. Time of Death 7:39P  |
| Examir<br>Funeral  |                            | 5. Social Security Number   | e at the L<br>6. Sex 7. Ag  | a ke<br>e (In yrs. last birt   | hday) If Un   | der 1 Year   | r Location of Deat  | . 8. Date of B   | irth   | 9.  | Death  Death  Birthplace (State or Foreig)  |
| Director   |                            | 214-10-6536  Usual Residence of Decedent  10a. State 10b. County  | 1 🗆 M 2 🔀 F   |  | Yrs. Monti  | ns Days  | Hours Min.  | 10/19  | /1918  | 3 M   | country)<br>aryland   |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Funeral Director           | Maryland Wicon  10e. Street and Number  | mico  | 10c. City, Towr  | lisbury   | Zip Code   |   |  | 1 40 6   |   | 10d. Inside City Limits 1  Yes 2 X N  |
| ath with ti<br>ems 23a<br>r must be  | uneral                     | 100 Roseberry   | y Ave.  | Ever in LLS  |   | 2180   |   | posify Voc or No   |  | itizen of What<br>USA   |   |
| ırs after de<br>ıral", or ite<br>I Examine   | ed by F                    | 1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced  | Armed Forces?   |  |   | pecify Cuba  | ispanic Origin? (S<br>in, Mexican, Puert<br>Specify:  | o Rican, etc.)   | )-   |   | American Indian,<br>Vhite, etc.  White  |
| hin 72 hou<br>ne.<br><b>than "natu</b><br>ie Medical   | Completed by               |   | nt's Education<br>st grade completed)  College (1-4 or 5  | +)   | Decedent's U<br>(Give kind of the life. DO NOT)                               | vork done d  | ation<br>during most of wo  | rking  | 1  | Kind of Busine  | ess Industry  |
| be filed with sutal Hygie ced other ced other centre the   | To Be C                    | 17. Father's Name (First, Middle, L<br>John R. Beasle   | ,   |  |   |  | 18. Mother's Nar  | me (First, Middle  |  |   | S Office  |
| d 2 should I   |                            | 19a. Informant's Name/Relationsh  | ip (Type, Print)  |  |   |  | and Number or Ru  | ral Route Numb   | er, City o   | r Town, State   | Zip Code)  Y, MD 21804  |
| Page 1 an<br>ment of He<br>ant: If iter<br>ury or othe   |                            | 20a. Method of Disposition  1 🔀 Burial 2 🗌 Cremation 4 🔲 Donation 5 🗍 Other (S  | 3  Removal from State   | 20b. Place of  | Disposition (A) y, crematory of LCO Men                                       | lame of  |   | Date 5/2012  | 20c. L   |   | or Town, State  |
| permit. Departi Import any inj   |                            | 21. Signature of Funeral Service  | nsee  | ~  |   |  |   |  |  |   | Association<br>804  |
| hysician/<br>Medical<br>Examiner   |                            | 236. Part . Enter the disease, or spock, or heart failure. List o mediate Cause (Final disease or condition resulting in death)   | a.  | the death. Do not be a consequence of  | ot enter the m  | ode of dying   | g, such as cardiac  | or respiratory a   | rrest,   |   | Approximate<br>Interval Between<br>Onset and Death                                  |
| an and<br>irial-transit  | ical Examiner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last  | Due to (or as a DEMENT  | YOPATHY consequence of TIA consequence of the conse | f):   |  |   |  |  |   |   |
| red by the attending physicial detached for use as the burn  | <b>\</b>                   | F FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 moords?<br>1  Yes No  | 1 Live Birth  | 23c. If yes, outcome of pregnancy  1  Live Birth 2 Fetal death 3 Ectopic pregnancy  4  Pregnant at time of death 5 Other (specify)  Month  |   |  |   |  |  |   |   |
| been signed by   | þ                          | Part II. Other significant condition  | ns contributing to death bu   | ut not resulting in  | the underlyin   | g cause give   | en in Part I.   |  |  |   | to the cause of death?  |
| 80   | Completed                  |   |   |  |   |  |   | 24a. Was<br>auto<br>perfo  |  | prior t   | autopsy findings available to completion of cause of ?                              |
| ate has be   | <u> </u>                   |   |   |  |   |  |   |  |  |   |   |
| this certificate has be<br>al director, page 2 sh  | To Be                      | 25. Was case referred to medical examiner?  1  Yes  No  |   | nt 2 🗆 ER/Out  |   | DOA Othe   | 4 L Nursing H   | k only one)  |  |   |   |
| after death.  Director: After this certificate has be in by the funeral director, page 2 sh  | To Be                      | examiner?   | 1 ☐ Inpatie  28a. Date of injur (Month, Day, ation of be  | Year) 28b. Ti  | me of<br>jury<br>M  | Other 28c. Injury work?  | r:<br>4  Nursing H<br>at  | ome 5 Resi   | dence on the dence of the dence | Other (Sp<br>y occurred   |   |
| n 24 hours after death.  e Funeral Director: After this certificate has be pleted filled in by the funeral director, page 2 shotted filled in by the funeral director, page 2 shotted filled in by the funeral director.   | Certificate: To Be         | examiner? 1   Yes 2   No  27. Manner of Death   Natural 5   Pending Investig. 3   Suicide 6   Could n determing  29a. Certifier 2   Certifying (Check 2   Medical Expression   Could be determing to the country of the | ation of be lead of line of l | y - At home, farm (Specify)  ny knowledge, damination and/or   | me of jury M m, street, factored investigation, i                             | 28c. Injury work? 1 \( \text{\tin}\text{\tetx{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texi}\text{\text{\texi}\text{\text{\texi}\text{\text{\text{\texi}\text{\text{\texi}\text{\text{\texi}\text{\text{\text{\text{\text{\text{\texi}\text{\t | r. 4 Nursing H at Yes 2 No  | ck only one)  ome 5  Resi 28d. Describe 1  28f. Location (8  City or Tov | dence how injury   | occurred  d Number or I   | Rural Route Number,   |
| after death.  Director: After this certificate has In by the funeral director, page 2  | Medical Certificate: To Be | examiner?  1  | 1 ☐ Inpatie  28a. Date of injur (Month, Day,  ation of be ned  28e. Place of Injur building, etc.   | Year) 28b. Ti<br>inj<br>y - At home, farm<br>(Specify)<br>ny knowledge, d<br>amination and/or<br>est of my knowle  | me of jury M m, street, factor eath occured a investigation, i dge, death occ | 28c. Injury work? 1 \( \text{\ti}\text{\texi{\text{\texi}\text{\text{\text{\text{\text{\text{\text{\text{\texi{\texi{\texi}\text{\texi{\text{\text{\text{\text{\text{\texi}\text{\text{\texi}\te | r. 4 Nursing H at Yes 2 No date and place, ai n, death occurred a time, date and pla number | ome 5 Resi 28d. Describe I 28f. Location (Society or Tou                 | dence show injury Street annown, State, uuse(s) arand place te cause(s) 29d. Date  | Other (Sp. y occurred  If Number or I  If Manner as and due to the standard manner as and manner as and manner as signed (Mo. | Rural Route Number, stated. le cause(s) and manner state as stated. nth, Day, Year) |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 26 per verb g928 6-26-12 vt

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 9:32 AM **Physician** 2012 JONII 15 James Leroy Handy, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Princess Anne If Under 1 Year | If Under 24 Hrs. Days Hours Min. Aurora Senior Living of Manokin 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 1 X M 2 ☐ F 5. Social Security Number **Funeral** 8-28-1921 MD 90 Director 219-03-5819 Usual Residence of Decedent 10d. Inside City Limits vithin 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a State If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No Director Upper Fairmount MD Somerset 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 8225 Upper Hill Road 21867 Funeral 12. Was Decedent Ever in U.S Armed Forces? Army Army 2 No If Yes, Give Year or Dates: 1945 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1∐Yes 2∏XNo Specify: Spectal ack þ 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Somerset Co. College (1-4or 5+) Elementary/Secondary (0-12) School System School Bus Contractor 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental Blanche Selby Isaac Handy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21367 19a. Informant's Name/Relationship (Type. Print) permit, Pages 1 and 2 D-partment of Health a Important; If Item 27 is any injury or other trau 8225 Upper Hill Rd, Upper Fairmount, MD Cynthia Handy/Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Upper Fairmount, MD Handy's Cemetery 4-21-12 4 Donation 5 Dother (Specify) Bennie Address of Fernity 917 W. Isabella St. 21. Signature of Funeral Service Licensee rusul Funeral Home Salisbury, MD\_21301 la nen Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 5 years **Physician** capile LUNG /Medical Due to (or as a consequence of 10 years Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 10410K attending physician and for use as the burfal-transit Exam ASWO Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 2 1 □ Ves 2 □ No 3 □ Probably 4 □ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? spital or Attending Physician: The ours after death, reral Director: After this certificate ifilled in by the funeral director, page 2 ∏ No 1 TYes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier who was 0051359 April 16 1 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415 S. DIVISION ST, SALISBURY, M921804 NATES AN. DR · USHA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State parke Registrar

(0

20

4/115/

GMPS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14776 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 16 2012 Lola E. Handy 1:22 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Worcester Berlin Nursing & Rehabilitation Center Berlin Social Security Number If Under 1 Year Funeral 6 Sex . Age (In vrs. last birthday, If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🛣 F Hours Maryland 08/02/1928 Director 221-50-6323 83 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 🏌 No Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 7943 E. Shire Drive 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. P 1 Never Married 2 Married Completed by Yes 2 X No Yes, Give should be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wallace Handy, Sr. Radie Handy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albin Handy, son Shire Drive, Berlin, Maryland 21811 Ε. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Curtis UMC Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 04/21/2012 Bishopville, Maryland 4 Donation 5 Other (Specify) Signatule of Funeral Service License 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD JOLLEY MEMORIAL CHAPEL 21801 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Trance Medical Due to (or as a onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: s, butcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy performe Yes 2 X No 1 Yes 2 🗆 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 XNo Other: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.
Funeral Director: After eted filled in by the funer. X Natural 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title D 20349 April 16, 2012

DHMH 17 Rev 7/2009

State

Registrar

310

HANDY

9715 Healthway Dr, Berlin,

MD

21811

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD,

Registrar's Signature

William H. Robins,

31. Date filed (Month, Day, Year)

APR

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

|  |                | For<br>State<br>Registrar  | Plea   | _                        | •  |                      |                          | Depa             |   | of H               | ealth                    |            | Mental Hy  |                        | 2                       |                      | 0 1                               | 477                         |
|--|----------------|--|--|--------------------------|--|----------------------|--------------------------|------------------|---|--------------------|--------------------------|------------|--|------------------------|-------------------------|----------------------|-----------------------------------|-----------------------------|
| Physicia<br>Medic<br>Examin  | al             | Decedent's Name     John     4a. Facility Name (if i   |  | Star                     |  | nber)                |                          | I                | Harris                                      |                    |                          | of Death   | 2. Date of De<br>Month                                   | 21                     | ty<br>. County          | Year                 | 2 07                              | of Death                    |
| Funeral  |                | Fewidsus.<br>5. Social Security Nu   | n Regi   |                          |  |                      | Cell<br>yrs. last bi     | •                | If Under 1                                  | <b>54</b> 41       | If Under                 | 24 Hrs.    | 8. Date of Bir   | th                     |                         | 9. Bir               | thplace (State                    | e or Foreign                |
| Director<br>≥  | r              | 220-38-40<br>Usual Residence o   |  | 1 🕱 N                    | 1 2 □ F  |                      | 69<br>c. City, Tov       | Yrs.             |   | Days               | Hours                    | Min.       | Jan. 2   |                        | 43                      |                      |                                   | n, D.C.                     |
| the Maryla<br>or 28a-fs<br>or notified   | I Director     | MD<br>10e. Street and Num  | Wicon<br>ober                                  | mico                     |  |                      | Sali                     | isbuı            | 10f. Zip (                                  | Code               | -                        |            | T  | 10g. Ci                | tizen of                | What Co              |                                   | Yes 2 No                    |
| 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  The teath and Mental Hygiene.  The marked other than "hatural", or items 23a or 28a-f show query? Is marked other than "hatural", or items 23a or 28a-f show query. The Medical Examiner must be notified at  | d by Funeral   | 617 N. Pa  | ed 2 🛭 Mari                                    | 12.                      | Was Dece<br>Armed Fo<br>1 2 Yes<br>If Yes, Giv<br>Year or Da | e 10                 | n U.S.<br>70 <b>–</b> 72 | If               |   | y Cuban            | , Mexica                 | n, Puerto  | ecify Yes or No-<br>Rican, etc.)                         |                        |                         | e - Ame<br>ck, Whit  | erican Indian<br>te, etc.<br>hite |                             |
| vithin 72 hour<br>iene.<br>r than "natul<br>the Medical  | Completed      | (Spec<br>Elementary/Seco<br>12   | 15. Deceder<br>cify only highe<br>ndary (0-12) | nt's Educa<br>st grade o | tion   |                      |                          | (Give k          | lent's Usual<br>kind of work<br>O NOT use r | done du<br>etired) | uring mos                | t of work  | ing  |                        |                         |                      | /Industry                         |                             |
| d be filed w<br>Mental Hyg<br>arked othe<br>tic event,   | To Be          | 17. Father's Name (F   |  | .ast)<br>tthev           | /s   |                      |                          | arris            |   |                    |                          |            | e (First, Middle,<br>May                                 | •                      |                         | e) _                 | tamm                              |                             |
| nd 2 shoule<br>ealth and I<br>m 27 is me   |                | 19a. Informant's Nar<br>Lynn Har   | ris- W   |                          | Print)   |                      |                          |                  |   |                    |                          |            | al Route Numbe   |                        |                         |                      | ip Code)                          |                             |
| permit. Page 1 ar<br>Department of H<br>Important: If iter<br>any injury or oth<br>once.   |                | 20a. Method of Disp<br>1  Burial 2<br>4  Donation  | X Cremation                                    |                          | moval from   | State                | cemet                    | tery, crem       | sition (Name<br>natory or oth<br>of D       | er place           | · ;                      |            | Date 22/2012   |                        |                         |                      | r Town, State<br>laware           |                             |
| Departition Depart |                | 21. Signature of Fun   | alle   | uy                       | Bh   | rke                  |                          | _   -            |   | Main               | n St                     | . Sa       | ounds F<br>Lisbury                                       | , MD                   |                         |                      |                                   |                             |
| Physician/<br>Medical<br>Examiner  |                | 23a. Rart 1. Enter the shock, or hear Immediate Cause (Fidisease or condition resulting in death)  | t failure. List c<br>Final                     | a.                       | ause on ea   | caused the ach line. | mu                       | 1) <del>4</del>  |   | , 5,               |                          |            | faim   |                        |                         |                      | Approxii<br>Interval<br>Onset ar  | mate<br>Between<br>nd Death |
| s be executed<br>sician and<br>e burial-transit  | cal Examiner   | Sequentially list cor<br>if any, leading to im-<br>cause. Enter Under<br>Cause (Disease or<br>that initiated events<br>resulting in death) L | mediate<br>lying<br>njury                      | b                        |  | (or as a con         |                          | e of):           | sepsi.                                      | <u> </u>           |                          |            |  |                        |                         |                      |                                   |                             |
| To the Hospital or Attending Physician: The law requires that the death certificate within 24 brous after death. within 24 brous after death. completely filled in by the funeral director, page 2 should be detached for use as the   | Physician/Medi | IF FEMALE: 23b. Was decedent   in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown  | nonths?  | 23c.                     | 1 Live   | nant at time         | Fetal dea                |                  | Ectopic pr<br>Other (spe                    |                    | ′                        |            |  |                        | 23d. Da                 | ite of de            | elivery<br>Day                    | Year                        |
| uires that ti<br>n signed by<br>uld be deta  | þ              | Part II. Other signifi   | cant conditions themselves                     |                          |  |                      |                          |                  |   |                    |                          |            | 23e. Did t   |                        |                         |                      | o the cause o                     | of death?                   |
| The law req<br>ate has bee<br>page 2 sho   | Completed      | 1  | renal  | Fail                     | re d   | u bo                 | ne                       | dren             | .I re                                       | real               | 20                       | ere        | 24a. Was<br>auto<br>perfo<br>1 \(\sum \) Yes             | psy                    |                         | prior to death?      | utopsy finding<br>completion of   |                             |
| hysician:<br>nis certific<br>il director,  | To Be (        | 25. Was case referre examiner? 1 Yes 2   | <b>K</b> No                                    | Hos                      | oital:   | npatient             | 2 □ ER/C                 | Outpatien        | t 3 🗆 DOA                                   | Othor              |                          |            | k only one)<br>ome 5 🗆 Resi                              |                        |                         | er (Spec             | cify)                             |                             |
| tending Paleath.  tor: After the funeral   | Certificate:   | 27. Manner of Death  1 X Natural 2 Accident 3 Suicide  | 5 Pendir<br>Investion                          | gation                   |  | th, Day, Yea         | ar)                      | . Time of injury | М   |                    |                          | - 1        | 28d. Describe I  |                        |                         |                      |                                   |                             |
| pital or At<br>burs after o<br>eral Direc'<br>filled in by   |                | 4 Homicide   | determ   | ined                     | buildi   | ng, etc. (Sp         | ecify)                   |                  | eet, factory,                               |                    |                          |            | 28f. Location (<br>City or Tov                           | vn, State              | )                       |                      |                                   | mber,                       |
| o the Hos<br>ithin 24 hc<br>o the Fun<br>ompletely   | Medical        | (Check   | Chifying                                       | xaminer:<br>Nurse Pi     | On the bas   | sis of examir        | nation and,              | l/or invest      | igation, in m                               | y opinior          | n, death o<br>e time, da | ccurred at | nd due to the c<br>t the time, date a<br>ace, and due to | and place<br>the cause | e, and du<br>e(s) and r | e to the<br>nanner a | cause(s) and                      | manner stated.              |
| 100  |                | 30. Name and addre   | LL   |                          | leted com  | en of doath          | (Itam 00c)               | \ (Type P        | 1-  | 450                | 7497                     |            |  | 4                      | 1/2                     | 1                    | 12                                |                             |
| 116  |                | Chris Soy  31. Date filed (Month   | de   | WIIO COM                 | 100 C  | . CAM                | innature                 | , (Type, P       | rint)<br>SALIS                              | ьил                | , 1                      | 2          |  |                        |                         |                      |                                   |                             |
| Stat<br>Registra   |                |  | PR 23  | 2012                     | B  | www.                 | A.                       | 100              | alle  |                    |                          |            |  |                        |                         |                      |                                   |                             |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death Physician/ Month 2012 12:40 P M Betty Ann Hooper Medical April 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 44099 Sandy Bottom Road Hollvwood St. Mary's Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Hours Director 1 □ M 2 🗓 F 577-38-4376 80 Yrs 05/15/1931 Martinsburg, WV Usual Residence of Deced ms 23a or 28a-f show must be notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 44099 Sandy Bottom Road USA 20636 Was Deceud.
Armed Forces?
Ves 2 No 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Examiner ō þ 1 Never Married 2 Married 1 Yes 24
If Yes, Give
Year or Dates Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White "natural", Completed 3

Widowed 4 □ Divorced Specify 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Secretary Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rufus Hamilton Penwell Georgia Anna Barton Penwell other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a : If item 27 is 37011 Mary Lane Mechanicsville, MD 20659 Linda A. Harris / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or Important: I any injury o 5/8/2012 Maryland Veterans Cem 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityBrinsfield-Echols Funeral Home, M00817 30195 Three Notch Road Charlotte Hall, MD 20622 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of): burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 You
9 Unknown ò Day Year Pregnant at time of death the Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy perform certificate 2 No Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 **X**No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending neral Director: A filled in by the f Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) En HW55751 30. Name and address erson who completed cause of death (Item 23a) (Type, Print) Jennifer M. Schmidt 40900 Merchants Lane Leonardtown, MD 20650 32. Registrar's State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day David McKinley Joynes ZZ38 04 20 20/2 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Peninsula Regional Medical Wicomico center Salisburd 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours (Month, Dav. Year) 220-28-4555 Director 1 🕶 M 2 □ F 79 July 1, 1932 VA Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Salisbury MD Wicomico 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21801 813 Miami Avenue death \ 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. ori Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify If Yes Give Specify: Black 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filk and Mental I ပ Carrie Justice Chancy J. Joynes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trae 813 Miami Avenue, Salisbury, MD 21801 George D. Joynes/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Acres Mem Park |4/28/2012 Salisbury, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 alana 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician AS CVI) disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? for Month Year 5 Other (specify) Dav Pregnant at time of death 2 No 9 Unknown g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed Yes 2 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗆 No မ 1 🖪 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA funeral 27. May er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending ours after death. leral Director; Ai filled in by the fu Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

STO

DHMH 17 Rev 06-2011

State

Registrar

Nalesa

APR 25 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATEGAN

1415

32 Registrar's Signature

D47094

4/20/12

5. DIVISION Steel 54/15 buy MD 2180

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14780 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 15, Day 2012 Year Physician/ Jones 2:30 рм Edward Henry Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Salisbury 29339 W. Naylor Mill Road If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min 1 🗶 M 2 🗌 58 05/30/1953 Maryland Director 186-44-3694 Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21801 29339 W. Naylor Mill Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married 1X Yes 2 Notional Maryland 21215-0036 If Yes, Give Nation Year or Dates. Guard Black 1 Yes 2 No Specify: Specify: 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Lucille Mumford 2 Edward Leon Jones 19a. Informant's Name/Relationship (Type, Print)
Kimberly Rayne/Cousin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12947 Worcester Hgwy, Bishopville, MD 21813 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Salisbury, MD Salisbury Crematory 4/24/2012 4 ☐ Donation 5 ☐ Other (Specify) atur of Funeral Service Holloway Funeral Home Professional Association 501 Hayward Ave., Salisbury, MD 21804 art 1. Enter the disease, or complication shock, or heart failure. List only one care aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Low disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (of as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate completed filled in by the funeral director, pag 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at w<u>ork</u>? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

4TC

Dr. Christian Bounds
State 31 Date filed (Month, Day, Year)

APR 25 2012

106 Milford St., Suite 605, Salisbury, MD 21804

and address of person who completed cause of death (Item 23a) (Type, Print)

Certificate of Deat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

31. Date filed (Month, Day, Year,

1 - For State Registrar

| h and I                | Mental Hy          | giene                              |                        |   |
|------------------------|--------------------|------------------------------------|------------------------|---|
| h                      |                    | Reg. No.                           |                        |   |
|                        | 2. Date of Dea     | ath _                              | .,                     | 3. Time of Death                            |
|                        | Month -            | - 20 -                             | 2012                   | 41:58cM                                     |
| ion of Death           | 2-00               |                                    | ty of Death            |   |
| 14                     |                    | Wie                                | OM,                    | .07   |
| der 24 Hrs.<br>rs Min. | 8. Date of Birt    | []                                 |                        |   |
| - IVIIII.              | 2-4-1              | 919                                | DE                     |   |
|                        |                    |                                    |                        | 0d. Inside City Limits                      |
|                        |                    |                                    |                        | 1 Yes 2 No                                  |
|                        | 1                  |                                    |                        |   |
|                        | 1                  | 10g. Citizen of<br>USA             | What Coun              | try?  |
| Origin? (Sp            | ecify Yes or No-   |                                    | ice - Americ           |   |
|                        | Rican, etc.)       |                                    | ack, White, e          |   |
| cify:                  |                    | Specif                             | Blac                   | K   |
| nost of worl           | kina               | 16b. Kind of                       | Business Ind           | dustry                                      |
| 551 57 11011           | ···· · 3           |                                    |                        | _   |
|                        |                    | Kern                               |                        | er Co                                       |
|                        | ne (First, Middle, |                                    | ne)                    |   |
| cooks                  | ie Smi             | ley                                |                        |   |
| mber or Rui            | ral Route Numbe    | r, City or Town,                   | State, Zip C           | Code)                                       |
| ircle                  | , Seaf             | ord, I                             | E 19                   | 973   |
|                        | Date               | 20c. Location                      | - City or To           | wn, State                                   |
| 4-27                   | -2012              | Hebror                             | ı. MD                  |   |
| acility917             |                    | abella                             |                        |   |
| 1                      | isbury             |                                    |                        |   |
|                        | or respiratory an  | -                                  |                        | Approximate                                 |
| 0                      |                    | 0.15                               |                        | Interval Between<br>Onset and Death         |
| JULI                   | MONAR              | y DISIZ                            | ASK                    |   |
|                        |                    | £1                                 |                        |   |
|                        |                    |                                    | _                      |   |
|                        |                    |                                    |                        |   |
|                        |                    |                                    |                        |   |
|                        |                    |                                    |                        |   |
|                        |                    |                                    |                        |   |
|                        |                    |                                    |                        |   |
|                        |                    |                                    | ate of delive<br>Ionth | ery<br>Dav Year                             |
|                        |                    | l IV                               | ЮПП                    | Day Teal                                    |
| Part I.                | 000 000            | phagas us = ===                    | tribute to to          | on cause of death?                          |
| cut I.                 |                    |                                    | - 1                    | e cause of death?                           |
|                        | 1 🗆                | Yes 2 No                           | 3 1 Prot               | bably 4 Unknown                             |
|                        | 24a. Was           |                                    | . Were autop           | osy findings available mpletion of cause of |
|                        |                    | rmed?                              | death?                 | 2/5Ro                                       |
| Death (Chec            |                    | Z LI NO                            | ( L 169                | 4 10  |
|                        | lome 5 🗆 Resid     | dence APO+                         | her (Specify           | HOSPICE                                     |
| _ rearrang fr          | 28d. Describe h    |                                    |                        |   |
| 2 🗆 No                 |                    |                                    |                        |   |
|                        |                    |                                    | ber or Rural           | Route Number,                               |
|                        | City or Tow        |                                    |                        |   |
| and place, a           | ind due to the ca  | use(s) and man                     | ner as state           | d.  |
| th occurred a          |                    | nd place, and d                    | ue to the cau          | use(s) and manner stated.                   |
| er<br>er               | oc, and due to th  | e cause(s) and r<br>29d. Date sign |                        |   |
|                        | ( )                | Ĭ                                  |                        | 91 - 07                                     |
| . 84                   | ( )                | 04/:                               | 20/12                  | -   |
| . 1.                   | 11. :              |                                    | 1-10                   | 20  |
| 5-62                   | y u                | 4/                                 | V 13                   |   |

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>012</u> April 21 Physician/ Mutoba Kankonde 2:28 РМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15230 Croom Rd. Brandywine Prince George's If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 213-35-1033 **Director** 55 1 🛛 M 2 🗆 F 6/22/1956 DRCongo 28a-f show aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified MD Prince George's Hyattsville 1XXYes 2 ☐ No 0 10e Street and Number 10f. Zip Code 10g. Citizen of What Countrythe Congo an "natural", or items 23a or Medical Examiner must be r Funeral 20781 Democratic Republic of 5128 Baltimore Ave. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 K Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. 27 is marked other than "r College (1-4 or 5+) Elementary/Secondary (0-12) event, the Engineer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Batubenga Kankonde Keleku Kanyinda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a 12640 Tierra Inca Dr., El Paso, TX Mutombo Kankonde / Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it 1 XBurial 2 Cremation 3 Removal from State Resurrection Cemetery 4/25/2012 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home NW Crain Hwy, Bowie, Maryland 20715 Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or head Immediate Cause (Final disease or condition resulting in death) 4106 Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Litter underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Brothers examiner? Hospital Other: 2 🗆 No ၉ ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Nother (Spec 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c, Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed

Registrar DHMH 17 Rev 06-2011

State

cause of death (Item 23a) (Type, Prin

251

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #25, PER State of Maryland Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death , 2012 Physician/ John J. Lichi April 18, 1:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wicomico Salisbury 1011 Hinman lane Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Days Hours 05/01/1926 277-20-1301 **Director** Ohio 85 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 **USA** 1011 Hinman lane 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. Army 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 4 Director of Education Civil Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Josephine Vitale Anthony Lichi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olga Lichi/Spouse 1011 Hinman lane, Salisbury, MD 21804 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Eastern Shore of MD 4/25/2012 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, MD Veterans Cemetery Signature of Funeral Service Licensee HOTTOWAY Tuneral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final DWSKK Physician/ lanur disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or imjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No een signed by the atte ould be detached for 5 Other (specify) Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? 2 🗆 No 2 4 Yes Division of Vital To the Hospital or Attending Physicians To Be 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐XNo Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed ' (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4/20/12 047044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISAUMY DIVISION Shew 2184 vel NATE SAN 1415 SO WA 31. Date filed (Month, Day, Year) APR 25 2012 Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ and Year Month 9:02 am Gladys Lewis Medical 4a. Facility Name (if not institution, give street and num Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSD 100 H10 Wicomic CIT Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours (Month, Day, Year) 1 □ M 2 🏋 F Director 220-01-9056 92 1-20-1920 Maryland Usual Residence of Deced show 10a. State 10b. County at 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No MD Wicomico Salisbury 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be Funeral 31844 Spearin Road 21804 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Law is a black S Baltimore, Maryland 21215-0036 ☐ Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Griffin Isabel1 Henry 011ie Ruark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31844 Spearin Road, Salisbury, Maryland 21804 <u> Mary Donoway - Daughter-in-law</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔲 Burial 2 🗓 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 4-20-2012 | Delmar, Delaware permit. 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service License arte Salisbury, Maryland E. Main Street, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate iterval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cauce. Enter or denying Cause (Disease or injury Examine Due to (or as a consequence of) for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year 1 Yes 2 to 9 Unknown Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed need 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has director, page 2 autopsy performed • Hospital or Attending Physician: The 24 hours after death. • Funeral Director: After this certificate! Yes 2 25. Was case referred to predical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

110

2. Registrar's Signature

ASTERN SHORE DE, SALISBURY, MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date Month 2. Date of Death Physician/ 1130 AM N-Lamb Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SALISBURY WIĆOMICO ANCHORAGE NURSING AND REHAB CENTER 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign Months Days Hours 1 K M 2 T F 01/19/1931 579-36-7756 Arkansas **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director X Yes 2 No Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 105 Times Square Room 309 21801 USA and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S ıral", or iten Examiner ı 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White "natural", 3 Widowed 4 X Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ပ Alberta (unknown) Lyle Lamb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip, Code 130 alleghany Rd., Stevensville, MD 21666 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Bruce W. Lamb/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Uniformed Svc. University ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) 4/16/2012 Health Sciences Bethesda, MD 21. Signature of Funeral Service Agensee <sup>22</sup> Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 KellIL 23a. Part 1. Enter the disease, or complexions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner SC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending physi IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Wunknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform completed filled in by the funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) of Vital examiner? Other: 4 Laursing Home 5 Residence 6 Other (Specify) 2 No Hospital: ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending Division 1 Yes 2 No 24 hours after death Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifier 57952 4/16/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Babulal Dr., 106 Milford ST #504B, Salisbun, MD21804 State Registrar's Signature

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene 20 | 2 | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ **Gilbert** Alvin Lewis April 14, 0350 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death 0akland Garrett Garrett County Memorial Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 **X** M 2 □ F 09/22/1932 Director 217-28-8872 Aurora, WV Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 21215-0036 WV Preston Terra Alta 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral HC 65 Box 121 26764 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ğ 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Trucking Truck Driver Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Chester McKinley Lewis Edith Rosela Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1515 Steyer Mine Road, Oakland, MD21550 Ronald Lewis (son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State WVU Memorial Vault 04/15/2012 Morgantown, WV X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility WVU Human Gift Registry 21. Signature of Funeral Service Licensee P.O. Box 9141, Morgantown, WV 26506 Robert Bolyard per DVR 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final 24 nset and Peath Physician/ disease or condition resulting in death) cardiogenic shock Medical Due to (or as a consequence of) 1 month **Examiner** ischemic cardiomyopathy Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): years that the death certificate be executed atherosclerotic cardiovascular disease and -trans that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical been signed by the attending r should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖰 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has le 2 performe this certificate 1 Yes 2 No Yes 2 🗵 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 🔼 No 1 A Inpatient 2 ER/Outpatient 3 DOA ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1XXNatural 5 Pending 1 Yes 2 No 2 Accident Investigation

Box 68760 P.O. Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** 

Medical

31. Date filed (Month, Day, Year) State MAY 0 9 2012 Registrar

3 Suicide 4 Homicide

29a. Certifier

29b. Signature

6 Could not be

and title of

determined

311 N Fourth Street Robert A. Goralski, M.D.

and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D23979

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21550

Oakland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Langley Month nes 2:35P M 2012 Medical April 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Charles Co. Nursing & 'Rehab. La Plata Charles . Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours Days 216-22-2483 **Director** 1 □ M 2 🖵 F 86 02/11/1926 Maryland Usual Residence of Decedent or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Charles La Plata 1 Xyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 10200 La Plata Rd. 20646 U.S.A. or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. White Armed Forces 1 Never Married 2 Married 72 hours after Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced If Yes, Give "natural", Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Supply, Inc. and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Book Keeper Be ather's Name *(First, Middle, Last)* Thomas Vincent Kersey 18. Mother's Name (First, Middle, Maiden Surname) Margaret Corrine Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10335 Newport Ch. Rd, Charlotte Hall MD 20622 19a. Informant's Name/Relationship (Type, Print)

Donald Langley - Son 1 and 2 s of Health item 27 i injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro. Crematory 05/01/12 Alexandria, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Raymond Funl. Service, P.A. J. M00641 5635 Washington Ave., La Plata, MD 20646 23a Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or). Cause (Disease or injury that initiated events resulting in death) Last sician and burial-tran Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work s after death.

I Director: Af 1 \sum Yes 2 🗌 No Accident Investigation 6 Could not be within 24 hours after dear To the Funeral Director completely filled in by the Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) at on Blud Ste B, Glen Bush C, MD 31. Date filed (Month, Day, Year) 32. Registrar's MAY 0 9 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ Month John W. Moore April 9:15 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Residence at Greenbelt Greenbelt Prince George's 8. Date of Birth (Month, Day, Jan. 20 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Hours 1 X M 2 - F **Director** 88 Yrs. 156-14-0666 Usual Residence of Decedent ms 23a or 28a-f show must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel 1 Yes 2x x No Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7806 Truitt Lane USA 21144 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Examiner Armed Forces?

1 Armed Forces?

1 Armed Forces?

1 Armed Forces?

1 Coast
Guard 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Black 3X Widowed 4 □ Divorced Year or Dates 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Chief Engineer Port Authority-Ny, Ny Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Moore Margaret Walden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $7806\ Truitt\ Lane,\ Severn,\ MD\ 21144$ Arlene K. Steward/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) 04/18/2012 Bloomfield, NJ Glendale Cemetery 21. Signature of Funeral Service Beall Funeral Home 22. Name and Address of Facility 6512 NW Crain Hwy., Bowie, MD 23a for 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 48 hours Immediate Cause Final disease or condition Physician/ Dehydration Medical resulting in death) Due to (or as a consequence of) **Examiner** 1 week Failure to Thrive Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transit 2 years Dementia Due to (or as a consequence of): resulting in death) Last Physician/Medical Parkinson's Disease 2 years Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Pregnant at time of death Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed certificate 2 🗌 No Yes 2x No Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 X Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/18/2012 D42719-MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20715 14300 Gallant Fox Lane, #118, Bowie, MD Μ. Carroll, M.D.,

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death AMENDED#7 & 4/20/12, M.S. Kent Co. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ ROBERT EARL MOSES 10:10 A M APRIL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CHESTER RIVER HOSPITAL CENTER CHESTERTOWN KENT 8. Date of Birth **Funeral** Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 X M 2 🗆 F Months Hours 06/21/1936 Director LOUISIANA 435-52-2927 Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 X No MD KENT CHESTERTOWN 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be n Funeral UNITED STATES 8990 GEORGETOWN ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. ō þ 1 Never Married 2X Married 1 Yes If Yes, Give 2 **X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates BLACK traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOME REMODELING / CARPENTER HOME IMPROVEMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be fill of Health and Mental item 27 is marked ပ GRADIE RABON DAN MOSES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8990 GEORGETOWN ROAD CHESTERTOWN, MARYLAND 21620 JAQUELINE MOSES / WIFE injury or other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place 4 Donation 5 Other (Specify) ASBURY U.M. CEMETERY 05/01/2012 CHESTERTOWN, MARYLAND 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 89 MD disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury use as the burial-transit that initiated events resulting in death) Last Due to attending physician Physician/Medical perulectoin Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HTW Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 46 Serzuce 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2010 N death? 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2NNo Other: မ 1 Phopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred To the Hospital or Attending Within 24 hours after death.

To the Funeral Director: After Natural (Month, Day, Year) injury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b, Signature and title of certifi to completed cause of death (Item 23a) (Type, Print) Name and address of perso MS 31. Date filed (Month, Day, Year 32. Registrar's Signature State 100 May

DHMH 17 Rev 7/2009

Registrar

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

Records,

**Division of Vital** 

Name and address of person who completed cause of death (Item 23a) (Type, Print Ramesh Sabapath 201-109 Back R

30641

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MILLE Physician/ Month 15 M 21 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Counta Ulnera OLUMBIA toware If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 093-20-3665 1 🗆 M 2 😿 F Months Days Hours Min. Director 85 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? "natural", or items 23a o Funeral 2820 Dana Court 21042 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify 3 ₺ Widowed 4 □ Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me any injury or other traumatic event, the Me once. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Clerk Tax Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Angelo Olevano Elva Molella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James G. Miller - son Ellicott City, MD 2820 Dana Court 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hanover, MD Ardent Crematory 04/23/2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Gelle 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final 5 Physician/ 0 disease or condition resulting in death) Medical Due to (or as a consequence of Examiner condidity has conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Day Year page 2 should be detached Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' after death.

Director: After this certificate 1 Yes Yes 2 No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2. No Other: ပု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier completed within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D3064 22 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramesh Sapapalli 201-109 Back River Neck Road State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 14792 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John W. Maier 8:55 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death oas the 1Comico +OSPICE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) If Under 24 Hrs. Min 357-28-2048 **Director** 1 🛣 M 2 🗆 F 74 06/24/1937 Illinois Usual Residence of Deced show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 X No Maryland Worcester Berlin 10e. Street and Number . Hygiene. I other than "natural", or items 23a or vent, the Medical Examiner must be r 10f. Zip Code 10g. Citizen of What Country? Funeral 8 Cape May Place 21811 USA - death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. Navy 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 4 Deputy Chief Secret Service Federal Government Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည John Hoff Florence Riordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mydra Maier/spouse 8 Cape May Place, Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Salisbury Crematory 4/19/2012 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LUNG disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Due to (or as a consequence or); Exami Cause (Disease or injury that initiated events attending physician and for use as the burial-tra Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death signed by the a Id be detached f Yes 2 No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has t performed within 24 hours after death.

To the Funeral Director; After this certificate I completely filled in by the funeral director, pag Yes /2 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0058410 T6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

ack

9

legistrar's Signatur

Year)

Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1434 PM Miller Gabriel Robert 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Peninsula Regional Medical Wicomico Salisbur Center If Under 1 Year If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday **Funeral** Days Hours Director 1 XM 2 🗆 F 9 Usual Residence of Decedent Maryland 04/04/2012 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Salisbury 1 Yes 2 X No Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral items 23a 21801 USA 29040 Red Fox Drive 72 hours after death Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Bace - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò 9 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural", White 3 Widowed 4 Divorced Completed 15 Decedent's Education Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) n|a and Mental Hygien is marked other th other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Tiffany Lea Holland Charles A. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is nany injury or attack. Charles A. Miller/Father 29040 Red Fox Dr., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗌 Burial 2 🛣 Cremation 3 🗍 Removal from State cemetery, crematory or other place) 4/17/2012 Salisbury, MD 4 Donation 5 Other (Specify) Salisbury Crematory Signature of Funeral Serving Holloway Funeral Home Professional Association Cetter 501 Snow Hill Rd, Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Msmy disease or condition Medical resulting in death) Due to (or as a conseque to e of) Examiner Sequentially list conditions. cause (Disease or Injury Quel to for as a nonsecond neigh-Exami The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Yea Pregnant at time of death 5 Other (specify) 2 No 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown page 2 should peen Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 1 ☐ Yes 2 🗶 No 1 Yes 2 No 25. Was case referred to medical examiner? Hospital or Attending Physician: Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 🗌 Yes ည 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) n 24 hours after death.

e Funeral Director: After the fetely filled in by the funeral 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 X Natural 5 Pending injury Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year, Mnocelle address of person who completed cause of death (Item 23a) (Type, Print) SAL156419

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day,

Year

100 E CARROLL

Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                                |   |              | State of Maryland /  |   |                                      | Mental Hyg                                  | giene  | 2 11.701   |
|--------------------------------|---|--------------|--|---|--------------------------------------|---|--|--|
|                                |   |              | Registrar  1. Decedent's Name (First, Middle, Last)  | Certificate of  | Death                                | 2. Date of Dea                              | Reg. No. ZUI                                   | 2 14/34  |
| П                              | Physicia<br>Medic   |              | AMANDA LYNN MINER  |   |                                      | Month<br>APRIL                              | Day Year 16 2012                               | 3. Time of Death 2:59 A M                          |
| Y                              | Examin  |              | 4a. Facility Name (if not institution, give street and number)   | 4b. City, Town,   | or Location of Death                 |   | 4c. County of Dea                              | th   |
| and the                        |   |              | FREDERICK MEMORIAL HOSPITAL  5. Social Security Number 6. Sex 7. Age (In yrs. last b   | FREDER  |                                      | 0 D-4 ( D)-41                               | FREDERIC                                       |  |
| T.                             | Funeral<br>Director   |              | 041-86-1777  Usual Residence of Decedent  Usual Residence of Decedent  | Months Days Yrs.  |                                      | 8. Date of Birth<br>(Month, Day,<br>9/8/198 | Year) Co                                       | rthplace (State or Foreign<br>ountry)<br>nnecticut |
|                                | land<br>f show<br>d at  | tor          | 10a. State 10b. County 10c. City, To   | wn or Location  |                                      |   |  | 10d. Inside City Limits                            |
|                                | Mary<br>28a-1<br>ootifie  | Director     |  | Jefferson   |                                      |   |  | 1 🗆 Yes 2 🛣 No                                     |
|                                | h with the  | Funeral [    | 10e. Street and Number 1425 Arnoldstown Rd.  | 10f. Zip Code<br>21   | 755                                  |   | 10g. Citizen of What C                         | ountry?  |
| 9800                           | e filed within 72 hours after death with the Maryland tral Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at  | by           | 11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☐ Yes 2 ☑ No  If Yes, Give  Year or Dates.  | 13. Was Decedent of If Yes, specify Cub  1 ☐ Yes 2X N                                       | ban, Mexican, Puerto                 | cify Yes or No-<br>Rican, etc.)             | 14. Race - Ame<br>Black, Whit<br>Specify: Whit | e, etc.  |
| Baltimore, Maryland 21215-0036 | vithin 72 hou<br>lene,<br>r than "natu<br>the Medica  | Completed    | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+) 4  | 6a. Decedent's Usual Occu<br>(Give kind of work done<br>life, DO NOT use retired<br>student | during most of worki                 | ing   | 16b. Kind of Business                          | /Industry  |
| land 2                         | d be filed waterial Hygurked other irked otherial tic event,  | To Be        | 17. Father's Name (First, Middle, Last) Peter J. Miner   |   | 18. Mother's Name                    | a Clear                                     | Maiden Surname)                                |  |
| Mary                           | ge 1 and 2 should be fili<br>it of Health and Mental<br>If item 27 is marked or<br>or other traumatic eve   |              |  | 9b. Mailing Address <i>(Stree</i>   |                                      |   |  |  |
| more,                          | permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.   |              | 1 Balial 2 Scremation 3 Removal from State cemes   | of Disposition (Name of stery, crematory or other plants of the burg Crema                  | ace)                                 |   | 20c. Location - City or                        |  |
| Balti                          | permit. F Departm Importa any inju  | (            | 21. Skinature di un Ser ce ricense   | 22 Name and Addr<br>Donald B  | ress of Facility Thompson Middletown | n Funera                                    | 1 Home   | , 110  |
|                                | Physician/  |              | 3a. Part 1. Enter the disease, or comblications that caused the death. Do shock, or heart failure. List only one cause on each line.   | o not enter the mode of dy  | ing, such as cardiac o               | r respiratory arre                          |  | Approximate<br>Interval Between<br>Onset and Death |
|                                | Medical<br>Examiner   |              | disease of condition resulting in death)  a. Due to (or as a consequence   | e of):  | ythmia<br>Fallot                     | _   |  |  |
|                                | HALF.   | ner          | Sequentially list conditions, if any, leading to him addition.   |   | rallo7                               |   |  |  |
|                                | ate be executed<br>hysiclan and<br>the burial-transit   | Examiner     | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence   | e off:  |                                      |   |  |  |
| 09                             | e be ex<br>ysiclan<br>ie buria  | dical E      | d.   | 3 31/1.   |                                      |   |  |  |
| 876                            | tificati<br>ng ph   | Med          | IF FEMALE:   |   |                                      |   |  |  |
| . Box 687                      | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi   | Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal dear 1 ☐ Pregnant at time of death g ☐ Unknown  |   | ncy                                  |   | 23d. Date of de<br>Month                       | livery<br>Day Year                                 |
| ls, P.O.                       | requires that the dea<br>been signed by the s<br>should be detached   |              | Part II. Other significant conditions contributing to death but not resulting  | g in the underlying cause g   | given in Part I.                     |   | pacco use contribute to                        | the cause of death?                                |
| Division of Vital Records,     | he law req<br>te has bee<br>age 2 sho   | Completed by |  |   |                                      | 24a. Was ar<br>autops<br>perforr            | prior to death?                                | topsy findings available completion of cause of    |
| E E                            | cian: T<br>ertifica<br>ector, p   | Be           | 25. Was case referred to medical examiner?   |   | Place of Death (Check                | 1 Yes :                                     | 2 M NO 1 L Ye                                  | s 2 No   |
| <u> </u>                       | Physic<br>this cral dire  | 욘            | 1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/C 27. Manner of Death 28a. Date of injury 28b  | Outpatient 3 L DOA  |                                      |   | ence 6 Other (Spec                             | sify)  |
| o u                            | nding I<br>tth.<br>: After<br>e funel   | cate         | 1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation  | injury M 28c. Inju  |                                      | 28d. Describe ho                            | w injury occurred                              |  |
| Divisio                        | al or Attendii<br>s after death.<br>I Director: Al<br>ed in by the fu   | Certificate: | 3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)   | farm, street, factory, office   |                                      | 28f. Location (Sti<br>City or Town          | reet and Number or Ru<br>n, State)             | ral Route Number,                                  |
| _                              | To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page  | Medical      | 29a. Certifier  (Check check conly one)  1 Certifying Physician: To the best of my knowledge conly one)  1 Medical Examiner: On the basis of examination and conly one)  3 Certifying Nurse Practitioner: To the best of my kn | d/or investigation, in my opin  | nion, death occurred at              | the time, date and                          | d place, and due to the                        | cause(s) and manner stated.                        |
|                                | To the within the complete of |              | 29b. Signature and title by Certifier  | 29c. Licens   |                                      |   | 9d. Date signed (Mont)                         |  |
|                                | 10  |              | 30. Name and address of person who completed cause of death (Item 23a)   | ) (Type, Print)   | DUNG!                                |   |  | 10 21701   |
|                                | Stat  | e            | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | 100 West  | - 14v2+                              | tred  | lenck, r                                       | 11) 21/01  |
|                                | Registra  |              | APR 2 3 2012 Jeneur &  | 1. parks  |                                      |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ 201 Malloy Medical Genevieve Anne 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland <u>WMHS-RMC</u> 6. Sex 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpiac Country) MD **Funeral** Hours Month, Day, Year) Jul 26, 1926 217-28-9043 Usual Residence of Deceden Director 1 M 2 X 85 28a-f show at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified MD Montgomery Silver Spring 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 4001 Randolph Road 20902 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 'natural", 3 Widowed 4 Divorced Completed white Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the homemaker own home Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked o traumatic eve ပ Alice Hanrahan Daniel F. McMullen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar. Important: If item 27 is any injury or other transone. MD 20902 Sean Malloy 4001 Randolph Road Silver Spring son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date emetery, crematory or other place) 1 🕱 Burial 2 🗌 Cremation 3 🔲 Removal from State 5/1/2012 SS Peter and Paul Cemetery Cumberland MD Donation 5 Other (Specify) 22. Name and Address of Eacility
Scarpelli Funeral Home, PA ≱ignature of Funeral Servic Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physi i n RESPIRATORY FAILWE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** PULMOMERY EMBOLI Sequentially list conditions, Examiner cause. Enter Underlying that the death certificate be executed Cause (Disease or injury that initiated events BRISYAST CANCER -trar Due to (or as a consequence of): resulting in death) Last the burial Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown bed 1 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPSPICHOLESTEROLEMIA Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPERCALCEMIA 24a. Was an autopsy performed 2 No 1 🗌 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 FR/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 5 Pending ours after death. Ieral Director: Aft filled in by the fur Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 24 hou

To the Fune

completely fi (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 047699 Ms Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. 12500 Willowbrook Rd. Cumberland, MD 21502 MIT 32. Registrar's Signatu State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

|   |  | Please Type or Print in Blace State of Maryland /   |                  |  |   | •                               |                   | .egible.                       |  |
|---|--|---|------------------|--|---|---------------------------------|-------------------|--------------------------------|--|
|   |  | For State Registrar   |                  | tificate of D  |   |                                 | Reg. No.          | 2013                           | 11.79  |
| Physicia  | m/   | 1. Decedent's Name (First, Middle, Last)  |                  |  |   | 2. Date of De                   |                   | Voor                           | 3. Time of Death                                   |
| Medic   | al   | Cynthia Lou McJonathan  |                  |  |   | 04<br>Month                     | 28 <sup>Day</sup> | 2012                           | 2:32 A M   |
| Examin  |  | 4a. Facility Name (if not institution, give street and number)  Meritus Medical Center  |                  | Hagerst  |   |                                 |                   | Washin                         |  |
| Funeral Director  |  | 5. Social Security Number 6. Sex 7. Age (In yrs. last bin 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1   |                  | If Under 1 Year<br>Months Days                                 | If Under 24 Hrs.<br>Hours Min.            | 8. Date of Bir<br>(Month, Da    | y, Year)          |                                | place (State or Foreign<br>ntry)                   |
|   |  | Usual Residence of Decedent   | Yrs.             |  |   | 09 01                           | L 1943            | Wayı                           | nesboro, PA  |
| filed within 72 hours after death with the Maryland<br>al Hygiene.<br>d other than "natural", or items 23a or 28a-f sho<br>went, the Medical Examiner must be notified at   | Director   | 10a. State   10b. County   10c. City, Tow   Waynest   |                  |  |   |                                 |                   |                                | 10d. Inside City Limits 1   1 Yes 2 □ No           |
| s 23a or  | Funeral D  | 10e. Street and Number 94 W. Main St.   |                  | 10f. Zip Code<br>17268   |   |                                 |                   | n of What Cou<br>US            | ntry?  |
| death<br>item   |  | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?   | 13. W            | /as Decedent of His<br>Yes, specify Cubar                      | spanic Origin? (Spe<br>n, Mexican, Puerto | cify Yes or No-<br>Rican, etc.) | 14.               | Race - Americ<br>Black, White, |  |
| urs after<br>tural", or<br>al Exami   | ted by   | 1 ☐ Never Married 2 🛣 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.  | 1                | ☐ Yes 2 💢 No   | Specify:                                  |                                 | Spe               |                                | ite  |
| 72 ho<br>n "na"   | Completed  | (Specify only highest grade completed)  | (Give ki         | ent's Usual Occupa<br>ind of work done d<br>) NOT use retired) | ation<br>Juring most of worki             | ng                              | 16b. Kind         | of Business/Ir                 | dustry   |
| within<br>giene.<br>er tha  |  | Elementary/Secondary (0-12) College (1-4 or 5+)   |                  |  | ive assis                                 | tant                            | yout              | h faci                         | lity   |
| l be filed<br>fental Hyg<br>rked oth<br>tic event   | To Be  | 17. Father's Name (First, Middle, Last) Paul M. Fox   |                  |  | 18. Mother's Name<br>Betty J.             |                                 |                   | name)                          |  |
| 12 should<br>alth and Me<br>27 is mar<br>r traumati   |  |   |                  | g Address (Street a  | nd Number or Rura                         | Route Numbe                     |                   |                                | Code)  |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.           |  | 1 Duvid 0 V Compation 0 Demonal from State Cemete   | rv. crem.        | sition (Name of<br>atory or other place<br>d Valley            | crem. 4/                                  | Oate 730/201                    |                   | tion - City or To<br>Lesboro   |  |
| permit. F<br>Departm<br>Importa<br>any inju   |  | 21. Signature of Funeral Service Ligensee   | 22.              | Name and Addres  | s of Facility Gro                         | ve-Bow                          | ersox             | Funera                         | 1 Home, Inc  |
| 9 9 E 8 9   |  | Thus Haille   | 5                | O S. Bro   | ad St. W                                  | laynesbo                        | oro, P            |                                |  |
| Physician/<br>Medical   |  | 23a. Part 1. Inter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  | not enter        | the mode of dying  | g, such as cardiac o                      | r respiratory ar                | rest,<br>U        |                                | Approximate<br>Interval Between<br>Onset and Death |
| Examiner  |  | Due to (of as a consequence   | of):             |  | 102                                       | lions                           | 1                 |                                |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying |   |                  |  |   |                                 |                   |                                |  |
| executed<br>in and<br>ial-transit   | Examiner   | Cause. Enter Underlying Cause (Disease or injury that initiated events  c.  | es               | leu si 6   | V   |                                 |                   |                                |  |
| g 2 2   | _  | resulting in death) Last Due to (or as a consequence  | of):             |  |   |                                 |                   |                                |  |
| ate be<br>ohysic<br>the b   | dica   | d   |                  | - <del>-</del>   |   |                                 |                   |                                |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be eximin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur | Completed by Physician/Medica  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown  |                  | Ectopic pregnancy<br>Other (specify)                           | у   |                                 | 230               | d. Date of deliv               | ery<br>Day Year                                    |
| hat the<br>ed by<br>detac   | y Ph   | Part II. Other significant conditions contributing to death but not resulting   | in the un        | nderlying cause give   | en in Part I.                             | 23e. Did to                     | obacco use        | contribute to t                | he cause of death?                                 |
| n sign  | q pe   | Diasetes mellitur, cl   | uor              | ric 2e   | ual                                       | 1 🗆                             | Yes 2 🗆 N         | No 3 Pro                       | babły 4 🗆 Unknown                                  |
| w requ  | plete  | daily so  |                  |  |   | 24a, Was                        |                   | 4b. Were auto                  | psy findings available                             |
| The lay   | Jow  |   |                  |  |   | autor<br>perfo                  | rmed?             | death?                         | mpletion of cause of                               |
| Physician: The law<br>this certificate has by   | Be C   | 25. Was case referred to medical examiner?  |                  | 26. Pla  | ace of Death (Check                       |                                 | Z IZNO            | 100                            |  |
| hysic<br>this ce<br>al dire   | မ  | 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ER/O   |                  |  | 4 U Nursing Ho                            | me 5 Resid                      | dence 6 🗌         | Other (Specify                 |  |
| tending Feath.  or: After the funer   | Certificate:   | 1 Natural 5 Pending (Month, Day, Year) i  | Time of<br>njury |  | at<br>?<br>Yes 2 No                       | 28d. Describe h                 | now injury oc     | curred                         |  |
| ital or Att<br>irs after d<br>ral Direct<br>lled in by  |  | 4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)   | ırm, stre        | et, factory, office  |   | 28f. Location (S<br>City or Tow |                   | umber or Rura                  | Route Number,                                      |
| To the Hospital or Attending P<br>within 24 hours after death.<br>To the Funeral Director: After<br>completely filled in by the funer   | Medical  | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, Medical Examiner: On the basis of examination and/only one)  3 Certifying Nurse Practitioner: To the best of my knowledge, The basis of examination and/only one) | or investig      | gation, in my opinior  | n, death occurred at                      | the time, date a                | and place, and    | d due to the ca                | use(s) and manner stated.                          |
| To T  |  | 29b. Signature and title of certifier Tahmod  | MD               | 29c. License   | o 632                                     |                                 | 29d. Date si      | igned (Month,                  | Day, Year) 2012                                    |
| 2841  |  | 30. Name and address of person who completed cause of death (Item 23a) (Shahid Mahmood MD)  | Type, Pr         |  |   | 2711                            | Aue               | Hage                           | 21742<br>M +wor M;                                 |
| Stat  |  | 31. Date filed (Month, Day, Year)  32. Registrar's Signature  | -4               |  |   | -                               |                   |                                |  |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 0swaldo Α. Nolasco 19 April 8:55 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min (Month, Day, Year) Director 577-17-2000 1 🖾 M 2 🗆 F 53 June 5, 1958 Usual Residence of Decedent El Salvador 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No P.G. Hyattsville 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 8300 14th Avenue, Apt. 202 20783 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 XXMarried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Salvadorean Specify: White If Yes, Give Year or Dates 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mason Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Mercedes Nolasco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reina Nolasco/Wife 8300 14th Avenue, Apt. 202, Hyattsville, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of April 26 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗵 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2012 Silver Spring, MD 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Boure Lochemic Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 1 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year 4 Pregnant Pregnant at time of death the detached g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Tonknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed' After this certificate 1 Yes 2 No director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ Sabyasach War, DO63703 04/20/12

DHMH 17 Rev 06-2011

State

Registrar

5

parke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

a dilad

SABYASACHI WAR

31. Date filed (Month, Pay, Year) APR 2 5 2012 7600 CARCOLL AVENUE

TAKOMA PARK, MO

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Richard L. Neal, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Richard L. Neal, Jr. April 29, 2012 Medical Examiner 0220 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director 212-70-2653 Months Days Hours 54 05/11/1957 Country) Maryland 1 X M 2 F Usual Residence of Decedent 'n 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland Anne Arundel Harwood permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene.
Important: If item 27 is marked other than "oatural", or items 23a or 28a-f she injury or other tranmatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4775 B Carmody Court 20776 ö 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Never Married 2 X Married Armed Forces? White, etc. Yes White 3 Widowed If Yes, Give Yeer 1 Yes 2 X No specify: Specify þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ltimore, MD 21215-0036 10 Mechanic Automobiles 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) æ Shirley Lawrence Richard L. Neal, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allison Neal/ Wife 4775B Carmody Court, Harwood, Maryland 20776 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State Kalas Crematory 5-2-12 Edgewater, Maryland 4 Donation 9 Other Specify 22 Name and Address of Facility George P. Kalas Funeral Home 21. ature of uneral Service Licensee 2973 Solomons Island Rd., Edgewater, MD 21037 Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and ca AMENDED 23a, pt. II, 27, per me, g927 5-10-12 sm X UNPENDED attending physician or use as the burial Physician/Medi Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of Other (Specify) Yes 2 No 9 Unknown 9 death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Chronic Obstructive Pulmonary Disease; Diabetes Completed 24a. Was an 24b. Were autopsy findings available **Mellitus** autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA 2 No 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural c Funeral Director: A letely filled in by the fu Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Nedical** within 2 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 29, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Melissa Brassell, MD 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year, 32. Registra State <u>MAY 0 9 2012</u> Registrar

ORIGINAL

OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene 14799 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Phoebus Edward Garland Jr. April 13, 2012 Year 10:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours 213-07-9423 **Director** 1**X** M 2 □ F 93 04/21/1918 Maryland or 28a-f show notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 9715 Healthway Drive 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No 14. Race - American Indian, "natural", or ite Black, White, etc. by 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 X No Specify: White Completed 3 X Widowed 4 Divorced Specify: er than "natur the Medical B 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than r traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, Maryland 21 Administrator Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eventoe. 2 Mable Crawford Edward Garland Phoebus Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward G. Phoebus III/Son 1108 Noves Dr., Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1  $\overline{\mathbf{X}}$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State Wicomico Memorial Park 4/18/2012 Salisbury, MD 4 Donation 5 Other (Specify) ovice A wo Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause opeach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of, and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s this certificate has 2 No Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Natural 5 Pending injury Division Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier 1 🚅 Certifying Physician: To tile best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical 5 aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certi 29c. License number 30. Name and address of perso who completed cause of death (Item 23a) (Type; Print) Khwaz Dr. Berlin MD Date filed (Month, Day, Year) Registrar's Signature 20 Registrar

0

3

3

4

DOD

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Riley J. Pitts, Jr. 0824 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester 5. Social Security Number 8. Date of Birth . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours 213-70-9955 **Director** 1 🛛 M 2 🗆 F 54 Yrs. Sept 2, 1957 MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Berlin 1 XYes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ems 23a or r must be r Funeral 119 Branch Street 21811 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Page 1 and 2 should be filed within 72 hours after deal ment of Health and Mental Hygiene. Fant, If item 27 is marked other than "natural", or iter iury or other traumatic event, the Medical Examiner. Armed Forces? Black, White, etc Completed by 1 X Never Married 2 Married Maryland 21215-0036 African-If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 Restaurant Chef Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Riley J. Pitts, Sr. Martha Sturgis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Shockley/mother 119 Branch St., Berlin, MD 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) St. Paul UMC Cemetery 4/14/2012 Signature of Funeral Service Licens 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 N Salisbury, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, eaching to in include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner signed by the attending physician and dbe detached for use as the burial-tran Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Medical Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The law performed' 1 Yes 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No 1 Inpatient 2 FR/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of 4/9/12 mpleted cause of death (Item 23a) (Type, Print)

0.0. 100 E Carroll St. 30 Name and addres Salisbuy My 21801 hris Juyder

Registrar

State

0874

TOD

37. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Charles Edward Peters,  $P^{M}$ 2012 April 21 1:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Arcola Health & Rehab. Center Silver Spring Montgomery

9. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 579-18-2996 April 11, 1918 Director VA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

nnt: If item 27 is marked other than "naturar", or items 23a or 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f show Director 1 ☐ Yes 2 ☐ No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 411 Hillsboro Drive 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 KYes 2 □ No If Yes, Give Year or Dates: 1941–45 1 ☐ Yes 2 ☑ No Completed by Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Education Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental ဥ Robert Peters <u>Ida May Smith</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau Althea Peters/Wife 411 Hillsboro Drive, Silver Spring, MD 20902

ce of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State April 28 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Rockville, MD 2012 Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Ent is the disease, or complications that cause in e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** reumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Lause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ospital or Attending Physiclan: The law requires that the death certificate be executed hours after death.

uneral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 □ Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

10+

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

9701 VEIRS OR 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHARMA

backer

ROCKVILLE, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Perkins Alice April 20, 5:30 am Marie Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sunrise Assisted Living Pikesville Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, Year) Director 577-38-4652 1 U M 2 🔀 F 80 Yrs Sept. 20, 1931 Washington, DC Usual Residence of Deced or 28e-f show other treumetic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 X No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 239 2709 Woodedge Road 20906 USA 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc. 6 δ 1 Never Married 2 Married e filed within 72 hours after itel Hygiene. ed other then "neturel", o Maryland 21215-0036 Specify: White 1 Yes 2 XNo Specify. Completed 3XXWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Security Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mentel F is marked of ဂ္ Lawrence L. Murray Mary B. O'Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr Def artment of Health an Important: If item 27 is any injury or other treui Janet M. Steinback/Daughter 2709 Woodedge Road, Silver Spring, MD 20906 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State April 24 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA Metropolitan Crematory 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Signature of Funeral Service License Alle 500 University Blvd. W., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition resulting in death) 10 year Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury physician and the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 use as the the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ξ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day 9 Unknown is certificate has been signed by director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 P No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completely filled in by the funeral director, page perform 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) GACILIA 1 ☐ Yes 2 No ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 1 within 2 To the F 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) R118354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lep

DHMH 17 Rev 06-2011

State

Registrar

Pasadena

MD 21122

Oak Rint

7900

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Year Physician/ Richard Michael Passarell Sr. April 27 9:30 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Williamsport 15534 Clear Spring Rd. 8. Date of Birth

Month, Day, Year)

Feb. 12, 1959 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 X M 2 D F 214-82-8835 53 Mary Tand **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director be notified 28a-f 1 🗆 Yes 2 🕅 No Williamsport Md. Washington ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 15534 Clear Spring Rd. 21795 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian Black White, etc. o. 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White "natural", 3 Divorced Year or Dates. ed other than "natu event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) nd Mental Hygiene. College (1-4 or 5+) Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ of Health and Menta item 27 is marked other traumatic e Michael Passarell Helen Talman 19a. Informant's Name/Relationship (Type, Print)
Patricia A. Passarell (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 15534 Clear Spring Rd. Williamsport, Md. 21795 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 T Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Smithsburg Crematory May 2012 Smithsburg, Md. 21. Signature of Funeral Service Lig 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home M01414 Smithsburg, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a c Examir attending physician and for use as the burial-transit Due to (or as a dinsequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) been signed by the atter should be detached for a in the past 12 months? Month Pregnant at time of death Dav Year 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director. After this certificate has been sis completed filled in by the funeral director, page 2 should to 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? perform Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's 2 No Hospital Other: ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending Accident 1 Tes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contifying Nursa Practioner: T. the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D 31. Date filed (Month, Day, Year, MAY 0 9 2012

Registrar

|  |                  | For State   |  | State of Ma                                    | arylan                                      |  | artment of<br>rtificate of                                  | Health and                      | Mental Hy                 |                           | 201                     | 2             | 11,20                               |  |
|--|------------------|---|--|--|---|--|---|---------------------------------|---------------------------|---------------------------|-------------------------|---------------|-------------------------------------|--|
|  |                  | Registrar  1. Decedent's Nam  | e (First Middle, La                        | st)  |   |  | incate of   | Death                           | 2. Date of De             | Reg. No.                  | 201                     | 3 Ti          | ime of Death                        |  |
| Physicia   |                  |   | Madeline                                   |  |   |  |   |                                 | Month<br>04               | 30                        | 2012                    | 6:            |                                     |  |
| /Medica<br>Examine   |                  |   |  | re street and number)                          |   |  | 4b. City, Town,   | or Location of Dea              |                           |                           |                         |               | 05 (                                |  |
|  |                  | Frostbu   | rg Villag                                  | e Nursing                                      | Cent  | er   | Frost   | ourg                            |                           | 1                         | Allegar                 | Ŋ             |                                     |  |
| Funeral  |                  | 5. Social Security N  | lumber 6. S                                |  |   | last birthday)   | If Under 1 Year<br>Months Days                              | If Under 24 Hrs                 |                           |                           | 9. Bir                  |               | State or Foreign                    |  |
| Director   |                  | 219-74-30   | J4 /                                       | шм 2 <b>д</b> ағ                               | 96  | Yrs.   | Yrs. 07 12 19   |                                 |                           |                           |                         | 915 Maryland  |                                     |  |
| and  | 1                | Usual Residence of<br>10a. State                                    | f Decedent<br>10b. County                  |  | 10c. Cit                                    | v. Town or Lo  | ; Town or Location  |                                 |                           |                           | 10d. Inside City Lim    |               |                                     |  |
| f sho  | <u>ē</u>         | MD  | Allegany                                   |  |   | Frostburg  |   |                                 |                           |                           |                         |               | Yes 2 □ No                          |  |
| the 28a-   | ်<br>မ           | 10e. Street and Nur   |  |  |   |  | 10f. Zip Code   | <u> </u>                        |                           | 10g. Citize               | en of What Co           | ountry?       |                                     |  |
| 3a ol  | ב <u>ֿ</u>       | 8 East Co   | nllege Av                                  | renite   |   |  | 21532 U   |                                 |                           |                           |                         | J.S.A.        |                                     |  |
| death  | Funeral Director | 11. Marital Status  | orrege VIV                                 | 12. Was Decedent                               |   | S. 13.   |   | Hispanic Origin? (              | Specify Yes or N          |                           | 4. Race - Am            |               | an,                                 |  |
| or ite   |                  | 1 Never Marri   | ied 2□ Married                             | Armed Forces?<br>1 □ Yes 2 📉 I<br>If Yes, Give |   | J.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1  Yes 2 No Specify: |   |                                 |                           |                           | Black, Whit             | e, etc.       |                                     |  |
| ural",   | d b              | 3 Widowed   | 4 Divorced                                 | Year or Dates:                                 |   |  |   |                                 |                           |                           | Specify:                | Whit          | e                                   |  |
| nati   | ere              | (Spec   | 15. Decedent's Ed<br>cify only highest gra | ducation<br>ade completed)                     |   | (Give  | dent's Usual Occu<br>kind of work done<br>DO NOT use retire | during most of wo               | rking                     | 16b. Kine                 | d of Business           | /Industry     |                                     |  |
| withir<br>ene.<br><b>than</b>  | Completed        | Elementary/Seco   | ndary (0-12)                               | College (1-4or 5                               | 5+)   |  | er/Manag  |                                 | Crease                    | Source C4                 |                         |               |                                     |  |
| filed<br>Hygi<br>other<br>ent, t   |                  | 17. Father's Name   | (First, Middle, Last)                      | )  |   | Owt  | er/ madag   | 7                               | me (First, Middle         |                           | cery St<br>Gurname)     | .ore_         |                                     |  |
| ld be<br>lental<br>ked c   | 0 26             | Charles   | Madigan                                    |  |   |  |   | Carrie                          | Hinebau                   | igh Ma                    | digan                   |               |                                     |  |
| shou<br>and M<br>s mar<br>umat   | -                |   | ame/Relationship (                         | Type. Print)                                   |   | 19b. Mailin  | ng Address (Stree   | et and Number or R              |                           |                           |                         | Zip Code)     |                                     |  |
| and 2<br>salth a<br>127 is<br>er tra   |                  | William 1   | Preston                                    | son  |   | 652 W  | . Countr  | y Club D                        | r. Egg t                  | Jarbor                    | : City,                 | , NJ          | 08215                               |  |
| es 1 g<br>of He<br>of Herr<br>ritem  |                  | 20a. Method of Disp   | •  | In   | 20b. P                                      | lace of Disposemetery, cren  | sition (Name of<br>natory or other pla                      | ace)                            | Date                      | 20c. Loc                  | ation - City or         | Town, Sta     | ate                                 |  |
| Pag<br>ment<br>ant: I<br>ury o   |                  |   | 5 ☐ Other (Specif                          | Removal from State                             | Fr  | ostbur   | g Mem Pa  | rk 05/0                         | 3/2012                    | Frost                     | burg,                   | MD            |                                     |  |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinate in control of any once.   |                  | 21. Signature of Fu   | neral Service Licer                        | nsee   | Mac   |  |   | ress of Facility S<br>In St., F |                           |                           |                         | P.A           | •                                   |  |
|  |                  | 23a. Part 1. Enter the shock, or heal immediate Cause               | art failure. List only                     | plications that caused<br>one cause on each li | the death                                   |  |   |                                 |                           |                           |                         | Interva       | ximate<br>al Between<br>t and Death |  |
| Physician<br>/Medical  |                  | disease or condition resulting in death)                            |  | a. Duala (arta                                 | rery  |  | u Can   | iov Ascul                       | er an                     | <i>-</i>                  |                         | - ye          | 'ng                                 |  |
| Examiner   |                  | Due to (or sea consequence of):                                     |  |  |   |  |   |                                 |                           |                           |                         |               |                                     |  |
|  | <u> </u>         | Sequentially list con<br>if any, leading to in<br>cause. Enter Unde | nditions,                                  | b. Due to (or as                               | a currendi                                  | nnew offr  |   |                                 |                           |                           |                         |               |                                     |  |
| rate be executed hysician and the burial-transit   | Cxammer          | that initiated events   |  |  |   |  |   |                                 |                           |                           |                         |               |                                     |  |
| e exe  | Ĭ                | resulting in death) Last Due to (or as a consequence                |  |  |   |  | nce of):  |                                 |                           |                           |                         |               |                                     |  |
| The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit   | 200              |   |  | d  |   |  |   |                                 |                           |                           |                         |               |                                     |  |
| leath certific<br>attending p  | ruysician/ined   | IF FEMALE:  |  | 000 16   |   |  |   |                                 |                           |                           |                         |               |                                     |  |
| attender of the contraction of t | <u>a</u>         | 23b. Was decedent<br>in the past 12                                 | months?                                    | 23c. If yes, outcome                           | 2 Fetal                                     | death 3  | Ectopic pregnan   | су                              |                           | 23                        | 3d. Date of de<br>Month | livery<br>Day | Year                                |  |
| the de   | 2                | 1 □ Yes 2 □<br>9 □ Unknown  |  | 4 ☐ Pregnant a<br>9 ☐ Unknown                  | it time of d                                | ea⊪ 5∟   | Other (specify)   |                                 |                           |                           |                         |               |                                     |  |
| e law requires that the dhas been signed by the e 2 should be detached   |                  | Part II. Other signif   | ficant conditions of                       | ontributing to death b                         | ut not resu                                 | ılting in the ur   | nderlying cause gi  | iven in Part I.                 | 23e. Did                  | tobacco us                | e contribute t          | o the caus    | e of death?                         |  |
| uires<br>n sigr  | 2                |   |  |  |   |  |   |                                 | 1 🗆                       | Yes 2□                    | ]No 3 □ P               | robably       | 4 Unknown                           |  |
| w red<br>s bee   | nataridillon     |   |  |  |   |  |   |                                 | 24a. Was                  | s an                      | 24b. Were a             | utopsy fine   | dings available                     |  |
| The la   | 1                |   |  |  |   |  |   |                                 | auto                      | psy<br>ormed?             | prior to<br>death?      | completio     | n of cause of                       |  |
| an: T  | ע ו              | 25. Was case refer  | red to medical                             |  |   |  |   | 26 Place of De                  | 1 □Yes<br>ath (Check only | 200 No                    | 1 ∐ Yes                 | s 2 □ No      | 3                                   |  |
| Physician:<br>r this certific<br>ral director, j   |                  | examiner?<br>1 ☐ Yes 2 ☐  | <b>(</b> 10                                | Hospital:                                      | ent 2 🗆                                     | ER/Outpatien   | t 3 DOA Ot  | to a second                     | Home 5 ☐ Res              |                           | □Other (Spe             | ecify)        |                                     |  |
| neral  | Ī                | 27. Manner of Death   | _  | 28a. Date of Inju                              | ry<br>v. Year)                              | 28b. Time of<br>Injury   |   |                                 | 28d. Describe             |                           |                         |               |                                     |  |
| Attending<br>r death.<br>ector: Aftel<br>by the fune   | Į                | 2 ☐ Accident  | 5 ☐ Pending investigation                  |  | Yes 2 □ No                                  |  |   |                                 |                           |                           |                         |               |                                     |  |
| tal or Attending F rs after death. ral Director: After led in by the funer   |                  | 3 ☐ Suicide<br>4 ☐ Homicide   | 6 Could not be determined                  | 28e. Place of Injubul                          | ury - At ho<br>c. <i>(Sp</i> ec <i>if</i> ) | me, farm, stre   | eet, factory, office  |                                 | 28f. Location (           | (Street and<br>wn, State) | Number or R             | ural Route    | Number,                             |  |
|  |                  | 29a. Certifier  | 1 Certifying Ph                            | ysician: To the best                           | of my kno                                   | wledge death   | accurred at the   | time date and place             | e and due to the          | Calleo(s)                 | and manner o            | e stated      |                                     |  |
| the Hosp<br>thin 24 hou<br>the Fune<br>ompletely fi  | מוכי             | (Check only one)  | 2 Medical Exam                             | niner: On the basis o<br>and manner sta        | t examina                                   | tion and/or in   | vestigation, in my  | opinion, death occ              | urred at the time         | , date and p              | place, and du           | e to the ca   | use(s)                              |  |
| within To the comp   | 1                | 29b. Signature and  | title of certifier                         |  |   |  | 29c. Licen  | se number                       |                           | 29d. Date                 | signed (Mon             | th, Day, Ye   | ear)                                |  |
|  |                  | · Van   |  |  |   | 221244   |   |                                 | 3/1/12                    |                           |                         |               |                                     |  |

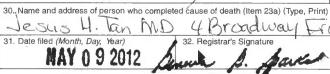
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State

31. Date filed (Month, Day, Year)

MAY 0 9 2012 Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day April 2012<sup>Year</sup> Oscar D. Richards 9 3:34 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Director 088-80-9752 88 1 🕱 M 2 🗆 F 4/15/1923 Guvana Usual Residence of Decedent 28a-f show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 Yes 2 X No MD Prince George's Bowie 0 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA "natural", or items 23: 20720 12611 Quoting Poet Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🕱 No If Yes, Give 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed Black Year or Dates other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Pharmacist Hospitals Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Richards Sophia Benjamin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other traur 12611 Quoting Poet Ct., Bowie, MD Bernice E. Richards / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State Lakemont Mem. Gards. 4/14/2012 Davidsonville, MD 4 Donation 5 Other (Specify) Signafure Fileral Servic Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Intracranial Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical P.O. Box 68760 IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Day Year g Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law autopsy performed? Yes 2 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 **(1**0 Other: မ 1 Hepatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury Natural work? 1 ☐ Yes 2 ☐ No Accident the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 7 29b. Signature and title

Registrar

State

Date filed (Mont)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Anthony Rufolo Month April 2012 5:41 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1586 Chocataw Road Arnold Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 073-14-8001 94 **Director** 1 🔀 M 2 🗆 F April 12, 1918 New York 10a State 10h County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Arnold ms 23a or 28a-f s must be notified Maryland Anne Arundel 1 Yes 2 XXVo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21012 1586 Chocataw Road U.S.A. "natural", or items dical Examiner mu Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner munder or other traumatic event. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Completed by 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes If Yes, Give 2 **XX**0 Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: White ₩Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **5+** Electrical Engineer Naval Research Lab Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Oresti Rufolo Anna Onesti 19a. Informant's Name/Relationship (Type, Print)

Marianne Graham/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 225 Batts Neck Road Stevensville, Maryland 21666 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory | 4/25/2012 Baltimore, Maryland 21. Signatur 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 1 Yes 2 L 9 Unknown detached Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at s after death. Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 028686 23 who completed cause of death (Item 23a) (Type, F

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month

20

strar's Signature

avra

51015

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ RICHARDS APRIL 05:00a<sup>™</sup> ROBERTA Α. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mt. Airy Montgomery Golden Years Assisted Living Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** Days (Month, Day, Year) **Director** 578-46-3600 74 Nov.12 1937 Washington, D.C. Usual Residence of Decede 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits must be notified at Director Frederick 1 Yes 2 X No MD Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21771 4046 Lomar Drive United States death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married þ Yes 2 🔀 No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Yes, Give 1 Yes 2 No Specify Specify: Completed 3 

Widowed 4 □ Divorced White Year or Dates if Health and Mental Hygiene. item 27 is marked other than "natul other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government 0 Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sandridge Sandridge Nan Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4046 Lomar Drive, Mt. Airy, Maryland Jamie H. W. Thomas / Daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 🗹 Burlal 2 🗆 Cremation 3 🗆 Removal from State Ouantico National 04/24/12 Triangle, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Muriel H. Barber Funeral Home 20882 P.O. Box 5038, Laytonsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Atherosclerotic Cardiovascular Disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Aortic Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ate has been signed by the atte page 2 should be detached for in the past 12 mo Day Year 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 No 1 Yes Yes 24 hours after death.

Funeral Director: After this certifice letely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Assisted Hospital မ 1 🗌 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be within 24 hours after de To the Funeral Director completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 1) 30 64-1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACK RIVER NECK ROAD BALTMORE MD 21221

State Registrar DHMH 17 Rev 06-2011

201-109 Registrar's Signature

SABAPATH

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2012 23 James B. Reed April 3:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Vindobona Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 ★M 2 □ F Months Days Hours Director 89 <u>231-22-9374</u> Oct.12 1922 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinant must be notified at any injury or other traumatic event, it a Medical Examina. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 📉 No VA. Frederick Winchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 116 Apache Trail 22602 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🟋 No Specify Specify: White Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 11 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Ollie Mae Cooper ည Owen Smith Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 116 Apache Trail Winchester, VA. 22602 <u> Anna Mann - Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory, or other place)
Lovettsville Union 2012 20a. Method of Disposition 20c. Location - City or Town, State Lovettsville, May Date 3 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Virginia 21. Sign ure of Funeral Service License 22. Name and Address of Facility Loudoun Funeral Chapel Cr SE Leesburg VA 20175 58 Catoctin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. HEART Onset and Death Immediate Cause (Final CONGE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence or, Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nis certificate has director, page 2 autopsy 1 □Yes 2 No. 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely one and manner stated within 2 To the I 29b. Signature title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Tolke

State 31. Date filed (Month, Day, Year)
Registrar NAY 0 9 2012

2012 Several A. Saule

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1004663

DELVE, PETOTALE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mend #4a PerPhy &#10e&19b Per FH G927 5/24/2012 JH

State of Maryland / Department of Health and Mental Hygiene 2011 14809 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Apr 29, 2012 6:40 AM Rohr Stephen Medical 4a. Facility Name (if not institution, give street and number)

121 S. Massachusetts Ave. **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Cumberland If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 1 🗙 M 2 🗆 F Jan 15, Director 235-68-8246 68 or 28a-f shov of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Cumberland MD Allegany 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 221 124 S. Massachusetts Ave Funeral USA 21502 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CSX pipefitter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lois Jean Phillips Harold Rohr permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat once. 19a. Informant's Name/Relationship (Type, Print) 19b. M221 Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 424 S. Massachusetts Ave. Cumberland MD 21502 Janice Rohr wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Xremation 3 Removal from State 4/30/2012 Cresaptown MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Conce us Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence oi). attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No be detached for Pregnant at time of death Month Day Year signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð COPD Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law has bage ; autopsy performed? death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes 2 -No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 \_\_Inpatient 2 \_ ER/Outpatient 3 \_ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Fractioner: To the best of my knowledge, de-29b. Signature and title of certific 29d. Date signed (Month, Day, Year) ru 30, 2012 DO017565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Huy LoVale, MD 21502 Bollino 170 921 32. Registrar's Signat State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ RAYMOND 30° 2012 5:20A. **JAMES** RATKOWSKI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hillhaven Assisted Lvg. Nursing & Rehab Ctr. Adelphi Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Nov • 10, 1939 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days 1 ₹M 2 □ F New York 053-34-2821 72 Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 🗆 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9510 Evergreen Street 20901 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. <u>Ş</u> 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates 1962-1965 3 - Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Painter Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Ratkowski Kurkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9510 Evergreen Street Silver Spring, Md 20901 Patrick W. Ratkowski -son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 5/1/2012 Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service License Bonald Words Borg Wardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of resulting in death) Last been signed by the attending physician should be detached for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No Haknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has I page 2 s performe Discaso 2 🗆 No this certificate 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🖪 No Hospital 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Natural
Accident
Suici 28b. Time of Certificate: 28c. Injury at 5 Pending work' 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical (Legistranger) (Legis 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. person who completed cause of death (Item 23a) (Type, Print) 4701 Randolph Rd #216. PUCKVILLE MD 20852

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Singletar Year Physician/ Month de 2012 3:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore University of Maryland Medical Center Baltimore City If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. **Director** 216-40-3692 1. ₹ M 2 □ F 68 1943 | Maryland Aug. 27, Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 X No MD Wicomico Salisbury 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 808 Seminole Boulevard 21801 USA 2 should be filed within 72 hours after death v th and Mental Hygiene. 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 X Widowed 4 Divorced Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10th Forklift Driver Koski Trucking Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ide Singletary, Sr. Mary Della Stanley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Beatrice Hoy/ Friend 808 Seminole Boulevard - Salisbury, Maryland 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō Department of Important: If it any injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Thompsontown Cemetery April 28, 2012 Fast New Market, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Salisbury, Maryland Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications th Approximate shock, or heart failure. List only one cause on Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) hrom bocytopenic Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Luisease or injury Examine Due to (or as a consequence of) burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IE FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Pregnant at time of death 2 No 1 Yes 2 L 9 Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 2 No Yes 2 1 1 Tes within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28c. Injury at work?
1 Yes 2 No Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 Pending iniury 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie R1315 23,2012 ou-Ellen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

alli

Low-Ellen 31. Date filed (Month, Day, Year) 22

Raistrar's Signature

Greene

South

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month R. Senkbeil Fred 1525 2012 9pri Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Salisbury Rehabilitation a Nursing Ctr . Social Security No 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last 1 **X** M 2 □ F Months Davs Hours (Month, Day, Year) 03/31/1930 218-28-3308 **Director** 82 Maryland Usual Residence of Decedent ar than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City. Town or Location with the Maryland 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No Maryland Wicomico Quantico 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21856 USA 4501 Whitehaven Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 X Never Married 2 Married δ altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than i Elementary/Seconday (0-12) College (1-4 or 5+) Trucking Truck Driver injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Lola Llovd Gust M. Senkbeil 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4698 Whitehaven Rd., Quantico, MD 21856 Department of Health an Important: If item 27 is any injury or other trat Mary Jane St. Lawrence/Friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Springhill Memory Gardens 4 Domation 5 Other (Specify) 4/27/2012 Hebron, MD Sign Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death relibraseuler lestee Physician/ disease or condition Lasz Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe after death.

Director: After this certificate 2 No 1 Yes Yes completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Yes Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 876 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 cho 31. Date filed (Month R 25 2012 Registrar's Signatu State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|   |   |                  | For<br>State  |   | State of Ma   | ryland             |                        | artment of l<br>tificate of l           |                          | and Me        | ,                                | •  | 2                        | 012                             | )                      | 181                         |
|---|---|------------------|---|---|---|--------------------|------------------------|---|--------------------------|---------------|----------------------------------|--|--------------------------|---------------------------------|------------------------|-----------------------------|
|   |   |                  | Registrar  1. Decedent's Nam  | e (First, Middle, Las                         | st)   |                    | 001                    | uncate or i                             | Deatir                   | 2             | . Date of De                     | Reg. N<br>ath  | lo. <u></u>              | 012                             |                        | e of Death                  |
|   | Physicia<br>Medio   |                  | Joan  | J. Shaw                                       |   |                    |                        |   |                          |               | Apri]                            | $\mathbf{l} \;\; \mathbf{l}^{\scriptscriptstyle \mathbb{D}}$ | 6 20                     | 12<br>12                        |                        | 42 P <sup>M</sup>           |
|   | Examin  | er               |   |   | street and number)                                    |                    |                        | 4b. City, Town, o                       |                          |               |                                  | 4  | c. County                | of Death                        | _                      |                             |
|   | Funeral   |                  | Atlan  5. Social Security N   |   | al Hospita  | l<br>(In yrs. last | hirthday)              | Berli If Under 1 Year                   | n, MD                    |               | . Date of Bir                    |  | Word                     | ceste                           |                        |                             |
| .,  | Funeral<br>Director   |                  | 160-26-2  | 8206  | □ M 2 🔀 F   | 80                 | Yrs.                   | Months Days                             | Hours                    | Min.          | (Month, Da<br>06/04/             | y, Year)<br>193  | 1                        | 9. Birthp<br>Count              | ry)                    | te or Foreign               |
|   | yland<br>f show<br>ed at  | ģ                | 10a. State  | 10b. County                                   |   | 10c. City, T       | own or Loc             | ation                                   |                          |               |                                  |  |                          | 10                              | Od. Inside             | e City Limits               |
|   | e Mar<br>28a-<br>notifie  | Funeral Director | DE  | Susse   | x   | Da                 | gsbor                  |   |                          |               |                                  |  |                          |                                 |                        | Yes 2 X No                  |
|   | ith th  | la<br>E          | 10e. Street and Nur   |   | n 1 1   |                    |                        | 10f. Zip Code                           | 0                        |               |                                  | 10g. C   |                          | /hat Count                      | ry?                    |                             |
|   | ems ?   | ine              | 11. Marital Status  | Hiawatha                                      | Boulevard  12. Was Decedent Ev                        | er in U.S.         | 13. V                  | 1993<br>Vas Decedent of H               |                          | gin? (Specify | v Yes or No-                     |  | U.S.                     | · A •                           | n Indian               |                             |
| TOD: 1942<br>Baltimore, Maryland 21215-0036 | should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at  | ğ                |   | ied 2  Married                                | Armed Forces?  1  Yes 2 N If Yes, Give Year or Dates. | lo                 | If                     | Yes, specify Cub                        | an, Mexicar              | n, Puerto Ric | an, etc.)                        |  | Blaci                    | k, White, e                     | tc.                    | 1                           |
| 2-0   | 2 hou<br>"natu<br>edica   | plet             | (Spe  | 15. Decedent's E                              |   | 1                  |                        | ent's Usual Occup<br>ind of work done   |                          | t of working  |                                  | 16b.   | Kind of Bu               | siness Ind                      | ustry                  |                             |
| 2121  | vithin 7<br>jiene.<br>er than<br>the M  | Completed        | Elementary/Sec<br>12  | onday (0-12)                                  | College (1-4 or 5+                                    | )                  | life. DO               | ) NOT use retired)<br>Banker            |                          |               |                                  |  | Bank                     | ing                             |                        |                             |
| pu  | filed v<br>tal Hyg<br>d othe  | o Be             | 17. Father's Name (   |   |   |                    | *****                  |   |                          |               | irst, Middle,                    |  |                          |                                 |                        |                             |
| 42<br>aryla                                 | uld be<br>I Men<br>marke<br>natic   | 2                |   | Brooks Jo                                     |   |                    |                        |   |                          |               | eth P                            |  |                          |                                 |                        |                             |
| .94<br>Ma                                   | ge 1 and 2 should be filed within<br>tt of Health and Mental Hygiene.<br>If item 27 is marked other tha<br>or other traumatic event, the I  | 1                |   | me/Relationship (T) W. Edward                 | <sub>/pe, Print)</sub><br>ls / Truste                 |                    |                        | g Address (Street<br>. <b>Black V</b>   |                          |               |                                  |  |                          |                                 |                        |                             |
| : ]   | of Hear fitem   |                  | 20a. Method of Disp   | position                                      | Removal from State                                    | 20b. Plac          | e of Dispos            | sition (Name of<br>atory or other place |                          | Date          |                                  |  |                          | City or Tov                     |                        |                             |
| TOD   | permit. Page 1<br>Department of<br>Important: If it<br>any injury or o  |                  |   | ☐ Cremation 3 ☐ 5 ☐ Other (Specif             |   |                    |                        | m. Park                                 |                          | 4/27/         | 2012                             | Fe   | aste                     | rvill                           | e, F                   | PA                          |
|   | permit. Page 1 and 2 si<br>Department of Health a<br>Important: If item 27 i<br>any injury or other tra   |                  | 21. Signature of Fu   | geral Service Licens                          | asself  | noog               | 10                     | Name and Addre<br>Parsell<br>34874 At   | Funer                    | al Ho         | mes &                            | Cre  | mato                     | rium                            | 1997                   | 0                           |
| /12   |   |                  | 23a. Part 1. Enter to<br>shock, or hear                             | he disease, or com<br>rt failure. List only o | olications that caused the cause on each line.        | he death. D        | o not ente             |   |                          |               |                                  |  |                          |                                 | Approxir<br>Interval I | nate                        |
| 16,   | Phy i i Medical   | 9                | Immediate Cause (<br>disease or condition<br>resulting in death)    |   | d.  | non                |                        | 2m                                      | 004                      |               |                                  |  |                          |                                 | Onset ar               |                             |
| 4   | Examiner  |                  |   | ſ   | Due to (or as a d                                     | consequence        | ce of):                | 2 illu                                  | fun                      |               |                                  |  |                          |                                 |                        |                             |
| 9   |   | iner             | Sequentially list co<br>if any, leading to in<br>cause. Enter Under | nmediate                                      | Due to (or as a c                                     | consequence        | ce of):                |   | 1/                       | 1             | ina                              |  |                          |                                 |                        |                             |
| DOD   | executed<br>an and<br>rial-transit  | Examiner         | Cause (Disease or that initiated events resulting in death) I       | linjury                                       | c. Due to (or as a                                    | Dei                | Hen                    | so we                                   | He                       | ent           | DIE                              | eis  | 4                        |                                 |                        |                             |
| 0   | be sicii  | edical E         | resulting in death) i   | Last  | - Due 10 (01 de av                                    | consequent         | 00 01).                |   |                          |               |                                  |  |                          |                                 |                        |                             |
| 931   | certificate<br>nding physuse as the   | <b>Jedi</b>      | TL  |   | d   |                    |                        |   |                          |               |                                  | -1   |                          |                                 |                        |                             |
| <b>H</b> 39                                 | h certi<br>tendin<br>r use a  | an/N             | IF FEMALE:<br>23b. Was decedent<br>in the past 12 r                 | pregnant                                      | 23c. If yes, outcome of 1 Live Birth 2                |                    |                        | Ectopic pregnance                       | cy                       |               |                                  | 1  |                          | e of deliver                    | •                      |                             |
| 6/4/<br>Box                                 | he deat<br>y the at<br>iched fo   | Physician/M      | 1 Yes 2 1<br>9 Unknown  | No  | 4 ☐ Pregnant at t<br>9 ☐ Unknown                      | ime of deat        | th 5 🗌                 | Other (specify) _                       |                          |               |                                  |  | Mor                      | ith [                           | Day                    | Year                        |
| 3:<br>P.O                                   | s that t<br>gned b  | by P             | Part II. Other signif   | icant conditions c                            | ontributing to death but                              | not resultir       | ng in the ur           | derlying cause gi                       | ven in Part              | l.            | 23e. Did to                      |  |                          |                                 |                        |                             |
| DOB<br>rds,                                 | equire<br>een si  | eted             |   |   |   |                    |                        |   |                          |               |                                  |  | No No                    | 3 🗌 Proba                       | ably 4                 | <b>X</b> Unknown            |
| Seco  | To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending I completed filled in by the funeral director, page 2 should be detached for use as | Completed        |   | -11 (00×6) T.                                 |   |                    |                        |   |                          |               | 24a. Was autop<br>perfo<br>1 Yes | osy<br>rmed?   | d                        | /ere autops<br>rior to comeath? | pletion                | gs available<br>of cause of |
| Joan<br>Vital F                             | ician:<br>certific<br>ector,  | Be               | 25. Was case referre examiner?                                      |   | Hospital:   |                    |                        |   |                          | th (Check on  | ly one)                          |  |                          |                                 |                        |                             |
| J.  | Phys  | <u>ان</u>        | 1 ☐ Yes 2 ☐<br>27. Manner of Death                                  | <b>1</b> 100                                  | 1 Inpatien<br>28a. Date of injury                     | 28                 | Outpatient  b. Time of | 3 DOA Oth                               | 4 ∐ Nu                   |               | 5 Resid                          |  |                          |                                 |                        |                             |
|   | ath.<br>r: Afte   | icat             | 1 XNatural<br>2 Accident  | 5 Pending Investigation                       | (Month, Day, Y  | Year)              | injury                 | work                                    | Yes 2 🗆                  |               | . Describe ii                    | ow inju  | ry occurre               | Ų.                              |                        |                             |
| Shaw,<br>Division                           | l or Atte<br>after de<br>Directo<br>d in by th  | Certificate:     | 3 ☐ Suicide<br>4 ☐ Homicide   | 6 Could not be determined                     | 28e. Place of Injury<br>building, etc. (              |                    | , farm, stre           | et, factory, office                     |                          | 28f.          | Location (S                      |  |                          | or Rural F                      | Route Nu               | mber,                       |
|   | Hospita<br>24 hours<br>Funeral<br>sted filled   | Medical          | (Check 2  | Medical Exami                                 | sician: To the best of m<br>ner: On the basis of exa  | mination and       | d/or investi-          | pation, in my opinic                    | on, death oc             | curred at the | time date a                      | nd place   | and due                  | to the caus                     | e(s) and               | manner stated               |
|   | To the within To the comple   |                  | only one) 3<br>29b. Signature and                                   | A Certifying Nurs                             | e Practioner: To the be                               | est of my kn       | owledge, de            | eath occurred at the<br>29c. License    | e time, date<br>e number | and place, a  | nd due to the                    | e cause<br>29d. Da   | s) and mar<br>ate signed | ner as stat<br>(Month, Da       | ed.<br>ay, Year)       |                             |
|   | KE.   |                  | <b>P</b>  |   | 4   |                    |                        |   | L3128                    | 55            |                                  | Aj   | prıl                     | 17,                             | 20.                    | T.Z                         |
|   | 5   |                  | Mary Be   | rnal-Cl                                       | ompleted cause of dea<br>ark, FNP-                    | BC,                | 9715                   | Health                                  | nway                     | Dr, 1         | Berli                            | n,   | MD                       | 218                             | 11_                    |                             |
|   | Stat<br>Registra  | e<br>ir          | 31. Date filed (Month   | R 20 201                                      | 2 Registrar's   | - 2                | Span                   | Kel                                     |                          |               |                                  |  |                          |                                 |                        |                             |

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Danny James Stine 11:15 A.M 9-2012 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Holly Center -926 Snow Hill Rd. SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign Funeral 1 X M 2 D F Months Hours 49 Director 212-78-5015 Yrs 03/02/196 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Wicomico Salisbury 10e. Street and Numbe ō 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 926 Snow Hill Road, Holly Center 21804 USA items ? 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ō þ 1 X Never Married 2 Married Maryland 21215-6036 1 ☐ Yes 2 X No Specify: White "natural" 3 Widowed 4 Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) unknown unknown disabled n|a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Madeline Taylor Corbin Herman Frederick Stine Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19682 South Lake Dr., Manns Harbor, NC 27953 Health Betty Kitching/Sister Important; If item 27 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ō 9 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury ( 4 X Donation 5 Other (Specify) 4/20/2012 Anatomy Gifts Registry Hanover, MD 21. Signature of Funeral Service Licenses Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ NEUROENDOCRINE THMOR WITH LIVER MIZTASTASIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence or, Cause (Disease or linjury and that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) signed by the attending physician be detached for use as the burial Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) 4 Pregnant 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s autopsy performed 1 Yes 2 No Yes 2 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 2 1 No Other: 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 🗆 Nursing Home 5 Residence 6 - Other (Specify) HULLY CHATE 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at **Natural** 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deati To the Funeral Director. completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature as 29d. Date signed (Month, Day, Year) 00057410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar's Signatu 20 APR Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| lary Spicer   |                                      | I- For State  | tate of Maryland                                  |            | artment o:<br><i>rtificate</i> oi |                         |                    | Mental                      | Hyg       |                      | N-         | 2.0                                | 12                       | ı                  | 1 0            |
|---|--------------------------------------|---|---|------------|-----------------------------------|-------------------------|--------------------|-----------------------------|-----------|----------------------|------------|------------------------------------|--------------------------|--------------------|----------------|
| Physician   |                                      | Registrar<br>1. Decedent's Name (First, Midd                      | lle,Last)   |            |                                   |                         |                    |                             |           | Date of Dea          |            |                                    | 3. Time                  | of Dea             | 14 8<br>th     |
| Medical Examin  |                                      | Mary Spicer   |   |            |                                   |                         |                    |                             |           | Month<br>April 22, 2 |            | Year                               |                          | 9 hrs              |                |
|   |                                      | 4a. Facility Name (if not instituti<br>University Hospital        | on, give street and number)                       |            |                                   | 4b. City, To<br>Baltimo |                    | ocation of De               | eath      |                      |            | County of Dea                      |                          |                    |                |
| Funeral   |                                      | 5. Social Security Number   | 6. Sex 7. Ag                                      | e (In yrs. | last birthday)                    | If Under                | 1 Year             | If Under 24                 | Hrs. 8    | . Date of Bir        |            | Baltimo<br>D/YYYY 9. B             | irthplace (              | State or           | r              |
| Director  | 1                                    | 221-18-1064   | 1 M 2 X F   | 80         | Yrs                               | Months<br>i.            | Days               | Hours                       | Min.      | 7-18-                | 1931       | Fore<br>C                          | ign<br>ountn <b>))</b> e | 1awa               | are            |
| b   | ļ                                    | Usual Residence of Decedent<br>10a. State 10b. County             | · · · · · · · · · · · · · · · · · · ·             | 10a Cit.   | , Town or Locat                   | ion                     |                    |                             |           |                      |            |                                    | Tana Is                  | -1-1- 011          | 114-           |
| nw any  |                                      |   | sex   |            | aurel                             | ion                     |                    |                             |           |                      |            |                                    |                          |                    | y Limits<br>No |
| e Maryland<br>nr 28a-f shuw<br>lied at once.  | 흸                                    | 10e. Street and Number  |   |            | uur CI                            | 10f. Zip C              | ode                |                             |           | 11                   | 0g. Citize | en of What Co                      |                          |                    |                |
| the M.  |                                      | 11184 County  | Seat Hwv.   |            |                                   | 199                     | 956                |                             |           |                      |            | USA                                |                          |                    |                |
| death with the Maryland<br>or items 23a or 28a-f shu<br>must be notified at once.   | Funeral Director                     | 11. Marital Status  | 12. Was Decedent                                  |            |                                   | s Decedent              | of Hispa           | anic Origin?<br>Mexican, Pu |           |                      | - 1        | 4. Race - Ame<br>White, etc.       | rican India              | an, Blac           | k,             |
|   |                                      | 1 Never Married 2 N 3 Widowed 4 Div                               | 1 Yes 2   | X No       |                                   | Yes 2                   | 7                  | specify:                    | 0,10,110  | un, 010.)            |            |                                    |                          |                    |                |
| urs aft<br>tural"   | 핡                                    | 15. Decedent's Education (Spe                                     | or Dates:   | npleted)   | 16a. Deceden                      | nt's Usual O            | ccupatio           | n (Give kind                |           |                      |            | pecify: What<br>nd of Business     | lite<br>/Industry        |                    |                |
| 6 72 ho   | Completed                            | Eiementary/Secondary (0-12)                                       | College (1-4 or                                   | 5+)        |                                   |                         | ng life. C         | OO NOT use                  | retired)  |                      | 11.        | a to 1                             |                          |                    |                |
| within speed  | 틹                                    | 17. Father's Name (First, Middle                                  |   |            | C1e                               | erk                     | 110                | 3.Mother's Na               | ama (Fi   | rak Bêlalala B       |            | otel                               |                          |                    |                |
| 21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ie event, the Medica  | ည<br>Re                              | David Simpler   | , Last)   |            |                                   |                         | "                  |                             |           | raham                | naiden Si  | urriame)                           |                          |                    |                |
| D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygene. 7 is marked other than "natural", ar items 23a nr 28a-f sha marked other than "natural", ar items 23a nr 28a-f sha marked other than "natural", ar items 23a nr 28a-f sha marked other than "natural", ar items 23a nr 28a-f sha to nee |                                      | 19a. Informant's Name/Relations                                   | ship (Type, Print)                                |            | 19b. Mailing                      | Address                 | (Street a          | -                           |           |                      | ber, City  | or Town, Stat                      | e, Zip Coo               | de)                |                |
| MD and 2 sho saith and em 27 is   | -                                    | Beverly Dicke 20a. Method of Disposition                          | rson (daught                                      |            | 9102<br>Place of Dispos           |                         |                    |                             |           | ad Del               |            | De. 1                              |                          | hala               |                |
| Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If iten 27 is marked other than "natural", injury or other fraumatic event, the Medical Examiner   | 1                                    | 1 Burial 2 Cremation  |   | ate        | crematory or oth                  | ner place)              |                    | .                           |           |                      |            | •                                  | ·                        |                    |                |
| litim<br>nit. Pa<br>artmen<br>ortant  | H                                    | 4 Donation 5 Other S<br>21. Signature of Funeral Service          | pecify:<br>Licensee                               | Odo        | d Fellov                          | √S Ceπ<br>lame and Ad   |                    |                             | -29       | -2012                | La         | aurel,<br>700 We                   |                          |                    | 3              |
| Dep   | 1                                    | Holly Short-  | Hannigan  |            |                                   |                         |                    | -                           | ish       | aroon                | F.H.       | Laurel                             | -                        |                    | 956            |
| Physician   |                                      | 23a. Part I. Pitter the disease, or failure. List only one cause  | complications that caused                         | the death  | . Do not enter th                 | ne mode of o            | dying, su          | ich as cardia               | ac or res | spiratory arre       | est, shock | k, or heart                        |                          | ximate I<br>en Ons | et and         |
| Examiner  | L Complications of Multiple Injurios |   |   |            |                                   |                         |                    |                             |           |                      |            | 1                                  | Death                    |                    |                |
|   | .                                    | Sequentially list conditions,                                     | b   |            |                                   |                         |                    |                             |           |                      |            |                                    |                          |                    |                |
|   |                                      | if any, leading to immediate cause. Enter Underlying Cause        | Due to (or as a conse                             | equence o  | of):                              |                         |                    |                             |           |                      |            |                                    |                          |                    |                |
| pg sit  |                                      | (Disease or injury that initiated events resulting in death) Last | Due to (or as a conse                             | equence o  | of):                              |                         |                    | _                           |           |                      |            |                                    |                          |                    |                |
| O,  be executed sician and burial - transit   | edica                                | UNPENDED  | dAMENDED  |            |                                   |                         |                    |                             |           |                      | -          |                                    | +                        |                    |                |
| 60,<br>cate be ex<br>physician<br>he burial   |                                      | F FEMALE:   | 23c. If yes, outcon                               | ne of preg | nancy                             |                         |                    |                             |           |                      | 23d. I     | Date of deliver                    | <u> </u>                 | -                  |                |
| Sox 6876(  death certificate e attending phy for use as the t   |                                      | 3b. Was decedent pregnant in the past 12 months?                  | 1 Live birth                                      | time of de |                                   | tal death               | 3                  | Ectopic pre                 | gnancy    |                      | М          | lonth                              | Day                      | Yea                | ar             |
| Box e death the atte  | nysician/N                           | 1 Yes 2 V No 9 Un   | known 9 Unknown                                   |            | 5 <u>U</u>                        | ner (Specify            | " —                |                             |           |                      |            |                                    |                          |                    |                |
| that the detached   |                                      | Part II. Other significant condit                                 | ions contributing to death                        | but not r  | esulting in the u                 | nderlying ca            | ause giv           | en in Part I.               |           |                      |            | e contribute to                    |                          |                    |                |
| ls, P.C<br>quires that<br>en signed a   |                                      | -   | -   |            |                                   |                         |                    |                             | -         | 1 Yes                |            | No 3 Pro                           |                          |                    |                |
| cords,<br>law requir<br>has been s  | Сошріете                             |   | <del></del>                                       |            |                                   |                         |                    | -                           | -         | autop:               | sy         |                                    | completio                |                    |                |
| Vital Rec<br>ysician: The lis certificate director, page  |                                      | 25. Was case referred to medica                                   | 1   |            | <del></del>                       | 26                      | Place of           | Death (Che                  | ck onty   | 1 Yes 2              | No No      | 1 🕢 Y                              | es                       | 2                  | No             |
| Vital ysician ysician his certi directo   |                                      | examiner?   | Hospital: 1 / Inpatie                             | nt 2       | ER/Outpatient                     |                         | I O                | hac —                       |           | ome 5 🗍 I            | Residenc   | e 6 Othe                           | r:                       |                    | =              |
| ling Ph<br>After ti<br>funeral  |                                      | 27. Manner of Death   | 28a. Date of Inju<br>(Month, Day You              | ry<br>ear) | 28b. Time of Ir<br>1748 hrs       | ·                       |                    | at Work?                    |           | l. Describe h        |            | occurred<br>to collision           |                          |                    |                |
| Sior<br>Attend<br>r death.<br>rector:<br>by the   |                                      | Pend  | stigation   |            |                                   |                         |                    | s 2 <b>✓</b> No             |           |                      |            |                                    |                          |                    | 0"             |
| Division o<br>spital or Attending<br>tours after death.<br>neral Director: After<br>filled in by the fune   |                                      |   | d not be 28e. Place of Inj                        |            |                                   | et, ractory, or         | nice buil          | aing, etc.                  | 1         | or Town, St          | ate)       | l Number or Ri<br>Rementer Ro      |                          |                    |                |
|   |                                      | 29a. Certifier 1 Certifying P                                     | hysician: To the best of my                       | / knowled  | ge, death occur                   |                         |                    |                             | and due   | to the cause         | e(s) and r | manner as stat                     | ed.                      |                    |                |
| To the Hos within 24 h To the Fur   |                                      |   | miner: On the basis of exar<br>and manner stated. | nination a | nd/or investigati                 |                         |                    |                             | ed at the | time, date a         |            |                                    | · ·                      |                    |                |
| •   | 2   2                                | 29b. Signature and title of certifie                              | PT  |            |                                   |                         | icense r<br>D.C.M. |                             |           |                      |            | ite signed <i>(M</i> o<br>23, 2012 | nth, Day,                | Year)              |                |
| 10  |                                      | 30. Name and address of person                                    | who completed cause of d                          | eath (Item | 23a)                              |                         |                    |                             |           |                      | p/11/2     | ,                                  |                          |                    |                |
| Q   |                                      |   | istant Medical Exam                               |            | 900 W. Balti                      |                         | eet, Ba            | altimore, I                 | MD 21     | 1223                 |            |                                    |                          |                    |                |
| Stat<br>Registra  |                                      | 31. Date filed (Month, Day, Year)<br>APR 2 4 20                   | )12 Server  |            | franks                            | d                       |                    |                             |           |                      |            |                                    | -                        |                    |                |
| - Regionic  |                                      | ULIT M ? E  | No.   |            | 9                                 |                         |                    |                             |           | O.C                  | WE         |                                    |                          |                    |                |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                                 |   |   | For<br>State<br>Registrar  | State of N  | laryland / De<br>C                                     | oartment of<br>ertificate of              |                 | and M       |                                   | giene<br>Reg. No. 2    | ו חי                 | 2 11                                    | , 2                 |
|---------------------------------|---|---|--|---|--|---|-----------------|-------------|-----------------------------------|------------------------|----------------------|---|---------------------|
|                                 | Dhusisis  | /   | 1. Decedent's Name (First, Middle  | , Last)   |  |   |                 |             | 2. Date of Dea                    | ıth                    | <del>- U - i</del>   | 3. Time of                              | Death               |
| ن دھر                           | Physicia<br>Medio   |   | Harry  | Norman  |  | Smith                                     |                 |             | Month<br>4                        | 15<br>Day              | 2012                 | 00:45                                   | $\mathbf{A}^{M}$    |
|                                 | Examin  | er  | 4a. Facility Name (if not institution,                                       | ,   |  | 4b. City, Town,                           |                 | of Death    |                                   | 4c. County             |                      |   |                     |
|                                 | Funeral   |   | 503 Tressler Dr: 5. Social Security Number                                   |   | ge (In yrs. last birthda)                              |   | sbury           | 24 Hrs.     | 8. Date of Birtl                  |                        | Comic                | hplace (State or                        | r Coroles           |
|                                 | Director  |   | 147-16-5838  | 1 🗓 M 2 🗆 F   | 89 Yrs.  | Months Days                               |                 | Min.        | 5-12-15                           | Year)                  | Cot                  | inplace (State of<br>untry)<br>W Jersey | roreign             |
|                                 | m o d   | L   | Usual Residence of Decedent  10a. State 10b. County                          |   | 140 00 7   |   |                 |             |                                   |                        |                      |   |                     |
|                                 | ırylanı<br>a-f sh<br>ïed a  | Director  | ,  | _   | 10c. Clty, Town or                                     |   |                 |             |                                   |                        |                      | 10d. Inside Cit                         |                     |
|                                 | or 28   | Öİ  | MD Wico  | omico   | ] Sal  | isbury<br>10f. Zip Code                   |                 |             |                                   | 10g, Citizen of        | What Co              |   | Z AJ NO             |
|                                 | with the 23a cast be  | era   | 503 Tressler Dri   | ive   |  |   | 1801            |             |                                   |                        | JSA                  | unity?                                  |                     |
|                                 | tems<br>er mu   | Funeral   | 11. Marital Status   | 12. Was Decedent                                      |  | . Was Decedent of                         | Hispanic Orig   | gin? (Spec  | cify Yes or No-                   |                        |                      | rican Indian,                           |                     |
| 36                              | after of ", or lamin  | ğ   | 1 Never Married 2 X Marr   | ied Armed Forces' 1 X Yes 2 If Yes, Give              | 1943 <b>-</b>  | If Yes, specify Cut  1 ☐ Yes 2 🔀 N        |                 |             | rican, etc.)                      |                        | ck, White            | e, etc.                                 |                     |
| 8                               | ours a  | etec  | 3 Widowed 4 Divorced   | Year or Dates.<br>t's Education                       | 1944   | edent's Usual Occu                        |                 |             |                                   | Specify                | WILL                 |   |                     |
| 715                             | an "na<br>Media   | Completed   | (Specify only highe  | st grade completed)                                   | (Giv   | e kind of work done<br>DO NOT use retired | during most     | of workir   | ng                                | 16b. Kind of B         | usiness l            | ndustry                                 |                     |
| 212                             | withir<br>giene<br>er th  | e Co  | Elementary/Seconday (0-12)   | College (1-4 or 5+                                    |  | eterinari                                 | an              |             |                                   | Medi                   | ica1                 |   |                     |
| pu                              | filed tal Hy de oth   | To Be   | 17. Father's Name (First, Middle, L.   |   | _  |   |                 |             | (First, Middle, I                 | Maiden Surnam          | e)                   |   |                     |
| <u>√</u>                        | uld be<br>i Men<br>narke<br>natic   | -   | Ernest   | Α.  | S  | mith                                      | Naomi           | -           |                                   |                        |                      | White                                   |                     |
| Ma                              | 2 sho<br>th and<br>27 is r<br>traun   |   | 19a. Informant's Name/Relationsh   |   |  | iling Address (Stree                      |                 |             |                                   | •                      |                      | •                                       |                     |
| ē,                              | l and<br>l Heal<br>tem 2  | 1   | <u>Madlyn Smith -</u><br>20a. Method of Disposition                          | Wife  | 20b. Place of Dis                                      | Tressler                                  | Drive           |             | lisbury<br><sub>ate</sub>         | Maryl<br>20c. Location |                      |   |                     |
| mo                              | age fent of   |   | 1 ☐ Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (S)                       | 3 Removal from State                                  |  | ematory or other pla                      |                 |             |                                   | Delmar                 |                      |   |                     |
| Baltimore, Maryland 21215-0036  | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.                                  |   | 21. Signature of Furniral Service Li   |   |  | 22. Name and Addr                         |                 |             | unds Fu                           |                        |                      | Laware                                  |                     |
| m                               |   | 23a. Pag 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, |  |   |  |   |                 |             |                                   |                        |                      |   | )4                  |
|                                 |   |   | shock, or heart failure. List or   | complications that cause<br>nly one cause on each lin | d the death. Do not e                                  | nter the mode of dy                       | ing, such as o  | cardiac or  | respiratory arre                  | est,                   |                      | Approximate<br>Interval Betw            |                     |
| -                               | Physician   | j o   | Immediate Cause (Final disease or condition                                  | — a.  | Ascv   | <b>フ</b>                                  |                 |             |                                   |                        |                      | Onset and D                             |                     |
|                                 | Medical<br>Examiner   |   | resulting in death)  | Due to (or as   | a consequence of):                                     |   |                 |             |                                   |                        |                      |   |                     |
|                                 |   | Jer   | Sequentially list conditions, if any, leading to immediate                   | b. — Due to (or as                                    | a consequence of):                                     |   |                 |             |                                   |                        | $\rightarrow$        |   |                     |
|                                 | uted<br>d<br>ansit  | Examiner  | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events | 6   |  |   |                 |             |                                   |                        | - 4                  |   |                     |
|                                 | execian an  | E   | resulting in death) Last   | Due to (or as   | a consequence of):                                     |   | _               |             |                                   |                        |                      |   |                     |
| 09                              | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit | dical   |  | d   |  |   |                 |             |                                   |                        | $\rightarrow$        |   |                     |
| Box 687                         | ertifica<br>ding p  | Physician/Mec   | IF FEMALE:   | 23c. If yes, outcome                                  | of pregnancy   |   |                 |             |                                   |                        |                      |   |                     |
| XO                              | atten<br>atten<br>I for u   | iciar   | 23b. Was decedent pregnant<br>in the past 12 months?<br>1 ☐ Yes 2 ☐ No       | 1 Live Birth  | 2 Fetal death 3  | ☐ Ectopic pregnar☐ Other (specify) _      | псу             |             |                                   |                        | ite of deliv<br>onth | ,                                       | ear                 |
| B                               | the de<br>by the<br>ached   | hysi  | 9 Unknown  | 9 🗆 Unknown   |  |   |                 |             |                                   |                        |                      |   |                     |
| Division of Vital Records, P.O. | v requires that<br>s been signed k<br>should be det   | by P  | Part II. Other significant condition   | ns contributing to death                              | but not resulting in the                               | underlying cause g                        | iven in Part I. |             |                                   |                        |                      | the cause of de                         |                     |
| ďs,                             | equire<br>en siç<br>ould t  | ted   |  |   |  |   |                 |             | 1 🗆 Y                             | es 2 🗖 No              | 3 Pro                | obably 4 🗆 U                            | nknown              |
| COL                             | law re<br>nas be<br>e 2 sh  | Completed   |  |   |  |   |                 |             | 24a. Was a<br>autops              | sy I                   | prior to co          | opsy findings av                        | /ailable<br>.use of |
| Re                              | rsician: The law rs certificate has t   |   |  |   |  |   |                 |             | 1  Yes                            | med?<br>2 No           | death?               | 2 🗆 No                                  |                     |
| ita                             | sician<br>certif<br>irector   | m   | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No                   | Hospital:   |  | Ott                                       | Place of Deati  |             |                                   |                        |                      |   |                     |
| of <                            | ding Physician: The Is. h. After this certificate ha funeral director, page   | e: To   | 27. Manner of Death  | 28a. Date of inju                                     |  | ent 3 L DOA                               | 4 ∟ Nui         | T           | ne 5 Reside                       |                        | -                    | fy)                                     |                     |
| on o                            | ath.<br>r: Afte   | icat  | 1 Natural 5 Pending 2 Accident Investig                                      | ation   | y, Year) injury  | M 1 🗆                                     | k?<br>☐Yes 2☐   | - 1         |                                   | ,,,,                   |                      |   |                     |
| NS.                             | r Atte  | Certificate:  | 3 ☐ Suicide 6 ☐ Could n<br>4 ☐ Homicide determi                              |   | ury - At home, farm, s<br>c. (Specify)                 | treet, factory, office                    |                 | 2           | 8f. Location (St.<br>City or Town |                        | er or Rura           | al Route Numbe                          | r,                  |
| ۵                               | oital o   |   |  |   |  |   |                 |             |                                   |                        |                      |   |                     |
|                                 | Hos<br>24 ho<br>Fune<br>eted f  | Medical   | (Check 2 L Medical Ex  | Physician: To the best of caminer: On the basis of    | examination and/or inve                                | stigation, in my opin                     | ion, death occ  | curred at t | he time, date an                  | d place, and due       | e to the ca          | ause(s) and man                         | ner stated.         |
|                                 | To the within To the Sompl  | _ ,   | only one) 3 L Certifying  29b. Signature and title of certifier              | Nurse Practioner: To the                              |  | 20c Licens                                | o number        |             |                                   | Od Data dans           | 1 /1 /1 - 4/-        | D- V                                    |                     |
|                                 |   |   | NA144  |   |  | Di  | 17091           | 1           |                                   | 4/1                    | 6/12                 |   |                     |
|                                 | TOP   |   | 30. Name and address of person w   | tho completed cause of c                              | death (Item 23a) (Type, 5 - ) i V i 5 / ar's Signature | Print)                                    | , ,.            | -1/15       |                                   | ~λ >                   | 1801                 | 4                                       |                     |
|                                 | Stat  |   | 31. Date filed (Month, Day, Year)  | 3. Registr  | ar's Signature   | UN SVER                                   | 34              | 11515       | 09                                |                        | _ /                  |   |                     |
|                                 | Registra  | _   |  | 012 Denus   | J. 190   | alla                                      |                 |             |                                   |                        |                      |   |                     |

12-02912 Sharon Sandusky

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

| 20       | 2     | 4       | 8      | 1 |
|----------|-------|---------|--------|---|
| Diam's A | Steme | <br>- 1 | $\sim$ |   |

| S   |                 | 1- For State Registrar Certificate of Death  | -   | g. No.                                       |  |
|---|-----------------|--|---|--|--|
| Physici<br>Medical Exami  |                 |  | 2. Date of Death<br>Month<br>April 13, 20 | 1  | 3. Time of Death<br>2217 hrs           |
|   |                 | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 7706 Stagg Road Snow Hill  |   | 4c. County of Dea<br>Worcester               | ıth                                    |
| Funeral<br>Director   |                 | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.  215-74-7176 1 M 2X F 55 Yrs. Hours Min.   |   | 1957 M8                                      | irthplace (State or<br>eign<br>Aryland |
| y any   |                 | Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  |   |  | 10d. Inside City Limits                |
| ryland<br>a-f shov  | ctor            | Maryland Worcester Snow Hill  10e. Street and Number 10f. Zip Code   | 140                                       | g. Citizen of What Co                        | 1 Yes 2 X No                           |
| th the Ma<br>23a or 28  | Il Director     | 7706 Stagg Road 21863  |   | USA  | unuyr                                  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner, must be notified at once. | y Funeral       | 11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Yeer  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1 Yes, specify Cuban, Mexican, Puerto   |   | White, etc.                                  | erican Indian, Black,<br>White         |
| hours a<br>'natural<br>Examin   | ed by           | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of w  | vork done                                 | 16b. Kind of Business                        |  |
| 0036<br>within 72<br>ene.<br>er than "  | Completed       | 12 – Bookkeeper  |   | Accounti                                     | ng                                     |
| 21215-0036 buld be filed within 7 Mental Hygiene. marked other than ic event, the Medical   | Be              | 17. Father's Name (First, Middle, Last)  George Alexander Keller  Lois E.  | (First, Middle, Ma<br>lizabeth            | ,  |  |
| MD 21<br>nd 2 should<br>alth and Me<br>m 27 is ma<br>sumatic co   | ٩               | 19a. Informant's Name/Relationship (Type, Print)  Cindy D. Staley/Sister  19b. Mailing Address (Street and Number or R 742 Danville Circle   |   |  |  |
| Ore, I ges 1 and to of Healt is if item that  |                 | 20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  | Date                                      | 20c. Location - City o                       | r Town, State                          |
| Baltimore,<br>permit. Pages I ar<br>Department of Hee<br>Important: If ite  |                 | 4 Donation 5 Other Specify: Salisbury Crematory 4/1 21 Signature of Funeral Service Licensee 22 Name and Address of Facility 1 LL  | .7/2012                                   | Salisbur                                     | y, MD                                  |
| മ്≗്≣<br>Physician  | -               | 21 Signature of Funeral Service Licensee  22 Name and Address of Facility Holloway Funeral  | Salisbu<br>respiratory arres              | ry, MD 21                                    | ASSOCIACION  Approximate Interval      |
| /Medical<br>Examiner  |                 | failure. List only one cause on each line.  Immediate Cause (Final disease a. Asphyxia by hanging  |   | t, onedit, of near                           | Between Onset and<br>Death             |
|   |                 | or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.  |   |  |  |
|   | Medical Examine | if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated   |   |  |  |
| (D,<br>e be executed<br>ysician and<br>burial - transit   | al Exa          | events resulting in death) Last  Due to (or as a consequence of):  d.  |   |  |  |
| 760,<br>cate be executed<br>physician and<br>he burial - transi   | Medica          | UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy   |   | Lood Data (Call                              | ii - I                                 |
| Ox 687<br>eath certifu  | Physician/N     | 23b. Was decedent pregnant in the past 12 months?  1   | су  | 23d. Date of deliver                         | y<br>Day Year                          |
| P.O. B<br>ss that the degreed by the  | by Ph           | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   | acco use contribute to                       |  |
| Cords, Flaw requires has been sign 2 should be  | eted            |  | 24a. Was an                               | 24b. Were a                                  | bably 4 Unknown                        |
| of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b   | Completed       |  | autopsy<br>perform<br>1 Yes 2             | ed? death?                                   | completion of cause of                 |
| Vital Rechysician: The this certificate   | 8               | 25. Was case referred to medical examiner?  1 Ves 2 No   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other   O | <del></del>                               | esidence 6 🗸 Othe                            | r. Coone                               |
| n of \ding Phy  | 일<br>:io        | 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 2   |   | w injury occurred                            | . ocere                                |
|   | Certification:  | Apr 13, 2012 2153 hrs Apr 13, 2012 258. Place of Injury - At home, farm, street, factory, office building, etc.  | 28f. Location (Stre                       | eet and Number or Ru                         | ıral Route Number, City                |
| the Hospital him 24 hours a the Funeral Inpletely filled  |                 | 4 Homicide determined (Specify) Residence 7  |   | e)<br>d, Snow Hill, MD                       |  |
| Divis  To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by   | g               | one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.  | the time, date an                         | d place, and due to th                       | e cause(s)                             |
|   | 2               | 29b. Signature and title of certifier  29c. License number  O.C.M.E.   |   | 9d. Date signed <i>(Mo</i><br>April 15, 2012 | nth, Day, Year)                        |
| 37C   | ŀ               | 30. Name and address of person who completed cause of death (Nem 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, N  | MD 21223                                  |  |  |
| Sta<br>Regist   |                 | 31. Date filed (Month, Day, Year) 2012 Seneral D. Sparker  |   |  |  |
| ricgist   | _الند           | Value of the same  |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 2. Date of Death 3. Time of Death Physician/ Day Month Smullen Jr. John Richard 2012 7;30 April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico Tyaskin 3388 Whitehaven Road Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. °Funeral 8. Date of Birth Birthplace (State or Foreign Country) 1 🗶 M 2 🗆 F Days 214-70-7413 0670171958 **Director** 53 Maryland Usual Residence of Decedent or 28a-f show 10a. State with the Maryland must be notified at 10c, City, Town or Location 10d. Inside City Limits Director Wicomico Tyaskin Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must be Funeral 21865 3388 Whitehaven Road USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 X Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Navy Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seafood Waterman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Richard Smullen Sr. Lena Belle Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a tant: If item 27 is 3388 Whitehaven Rd., Tyaskin, MD 21865 Deborah Smullen/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Salisbury Crematory 21. Signature of Funeral Service Licenses Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that initiated events and Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial /Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE Physician/ 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Dav Year 1 Yes 2 9 Unknown the Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital 2 □ No 1 🔲 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death. e Funeral Director: Aft bleted filled in by the fur 2 Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Getting Prijstelan. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Getting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2, To the F 29b. Signature and title of certifier 047094 NAKZ STLISBURY MD 21804 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415 5. DI VISION NATESAN 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

2012

APR

ank

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended#18 5/1/2012;rml;smc State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Day 2012 Physician/ Month April 18 8:00 p.m. Clifford Adams Spohn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Asbury Solomons Skilled Nursing Calvert Solomons If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth **Funeral** Hours Min. Director 188-05-4483 1 X M 2 □ F 96 12/21/1915 Usual Residence of Decedent <u>Pennsylvania</u> 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
7 item 27 is marked other than "natural", or items 23a or 28a-f show then traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Maryland | Calvert Solomons 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 20688 United States 11450 Asbury Circle, Apt. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Year or Dates White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Colonel United States Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret McTaggert Rankin Clifford Daniel Spohn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8712019a. Informant's Name/Relationship (Type, Print) Clifford A. Spohn, II/Son 6205 Cochiti Drive N.W., Albuquerque, New Mexico Baltimore, Date UNK- 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/08/2012 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia Arlington National 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD M01652 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fallure. List only one cause on each line. Metastatic Onset and Death Physician/ ANCER disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are the conditions of the conditions, if any leading to immediate causes of the conditions of t Due to lor as a consequence of Exami attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Medical certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 No Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law this certificate has autopsy performed' death? Yes 2 **Division of Vital** 25. Was case referred to medical examiner? completely filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 은 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? \_\_ 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After 1 Natural injury 5 Pendina Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month. Day. Year) 005 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 Hospital Road, Suite 310, Prince Frederick, MD 20678 John Barth, M.D. Registrar

Amended # 20B/Date 04/27/2012, RML, St. Mary's County

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

MAY 0 9 2012

Box 68760

P.O.

Records,

**Division of Vital** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Richard Taylor Jr. Raymond 2140 Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Salisbury Rehabilitationa Nursine Cto Wicomico lisbur Birthplace (State or Foreign Country) If Under 24 8. Date of Birth . Age (In vrs. last b Funeral 1 X M 2 🗆 F Months Hours 220-16-9396 Director 85 08/16/1926 Delaware Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 409 Decatur Ave. 21804 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" any injury or other transmits. 1 Never Married 2 Married ģ 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates. Army Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Raymond Richard Taylor Sr. Ruth Sherwood 19a. Informant's Name/Relationship (Type, Print)
Joseph S. Taylor Sr/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 428 Priscilla St., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State springhill Memory Springhill Memory Gardens 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/27/2012 Hebron, MD Signature of Funeral Service Licenses HOLLOWAY 501 Snow Funeral Home Professional Association Gomos Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Нe CAY disease or condition Medical resulting in death) or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown the 9 Unknown sate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? **Director:** After this certificate I 2 KNo 2 No ☐ Yes To Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **5** No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Day, Year)

State Registrar Nitholas

31. Date filed (Month, Day, Year)

APR 25 2012

istrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

sorodul in

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1:00 20 2012 Twilley 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Worcester Harrison Senior Living Snow Hill 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🛛 F Yrs 214-10-6552 89 Aug. 30, 1922 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Salisbury Wicomico 10e. Street and Number 10g. Citizen of What Country? 1500 Woodbridge Drive 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify. White Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maurice Jones Bertha Downes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Laura F. Twilley- Daughter-in-Law 1500 Woodbridge Dr. Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Salisbury, Maryland Wicomico Memorial Pk. 22. Name and Address of Facility Bounds Funeral Home belly 705 E. Main Street, Salisbury, Maryland 21804 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CEREBROVASULLAR Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

≥

Completed

ပ

10a. State

MD

**Funeral** 

Director

show

ir than "natural", or items 23a or 28a-f show the Worldal Experience must be conflided at

marked other than "natural", or

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event,

3altimore, Maryland 21215-0036

Examiner physician and s the burial-trans Physician/Medical ģ Completed Medical Certification: To

The law requires that the death certificate be executed Box 68760. attending p o. signed by the ۵. Records, cate has I page 2 s certificate of Vital this After thi funeral Division the Hospital or Attending hin 24 hours after death. To the Nosp...
within 24 hours, frer dean...
To the Funeral Unector. Aft
--lotely filled in by the fur

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 □Yes 2 NO 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated

29d. Date signed (Month, Day, Year) 4/20/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 1604 MARKET ST POLOMOKE GTY MD 21851. SATYAL SHARAD

29c. License number

D62172

31. Date filed (Month, Day, Year) APR 23 2012

29b. Signature and title of certifie

32 Registrar's Signatur

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012

|   |             | 1                                     | For State Registrar   | State of Ivia                       | aryıanc      | -                  | tificate of L   | Health and M<br>Death             |                            | giene<br>Reg. No. | 201                           | 2   | 1482                    |  |  |
|---|-------------|---------------------------------------|---|-------------------------------------|--------------|--------------------|---|-----------------------------------|----------------------------|-------------------|-------------------------------|---|-------------------------|--|--|
| Dhari   |             |                                       | Decedent's Name (First, Middle, Last)   |                                     |              |                    |   |                                   | 2. Date of Dea             | ath               | V                             | 3. T  | ime of Death            |  |  |
| Physic<br>Med   | dica        |                                       | Mary  | Mor1i                               | ng           |                    | Troy  |                                   | Month<br>4                 | 19 <sup>Day</sup> | 2012                          | 7:  | 02 A <sub>M</sub>       |  |  |
| Exam  | ine         |                                       | 4a. Facility Name (if not institution, give st  | ,                                   |              |                    |   | Location of Death                 |                            | 4c. C             | County of Deat                |   |                         |  |  |
| Funera  | al          | 5                                     | Village at Harbor .  5. Social Security Number   6. Sex   | 7. Age                              | (In yrs. las | st birthday)       | If Under 1 Year   | Salisbury If Under 24 Hrs.        | 8. Date of Birt            | h .               | Wico<br>9. Bin                | hplace (S   | State or Foreign        |  |  |
| Directo   |             |                                       | 214-28-4731   | M 2 💢 F                             | 87           | Yrs.               | Months Days   | Hours Min.                        | 3-8-19                     | 7, Year)<br>25    | Co<br>M                       | $\overset{\scriptscriptstyle{intry)}}{\operatorname{ary1}}$ | and                     |  |  |
| ind<br>show   |             |                                       | Usual Residence of Decedent  10a. State 10b. County   |                                     | 10c. City,   | Town or Loc        | ation   |                                   |                            |                   |                               | 10d. Inside City Limits                                     |                         |  |  |
| Maryla<br>18a-f<br>tified   |             | Director                              | MD Wicon  | nico                                |              | Sali:              | sbury   |                                   |                            |                   |                               | 1 [   | ☐ Yes 2 🌠 No            |  |  |
| h the la or 2   |             |                                       | 10e. Street and Number  |                                     |              |                    | 10f. Zip Code   |                                   |                            | 10g. Citize       | en of What Co                 | untry?  |                         |  |  |
| ath with  | 1           | = -                                   | 611 Tressler Drive  | Apt. 20                             |              | 112 14             | -   | 1801<br>ispanic Origin? (Spe      | eifr Vee or No             |                   | USA                           |   |                         |  |  |
| or ite  |             | Ž                                     | 1 Marrial Status 1 X Never Married 2 ☐ Married  | Armed Forces? 1 ☐ Yes 2 🗶 !         |              | If                 | Yes, specify Cuba   | n, Mexican, Puerto                | Rican, etc.)               | 14                | 1. Race - Ame<br>Black, White |   | an,                     |  |  |
| "natural", o  |             |                                       | 3 🗌 Widowed 4 🗌 Divorced  | If Yes, Give<br>Year or Dates.      |              | 1                  | ☐ Yes 2 🔀 No  | Specify:                          |                            | Sp                | pec <i>ify:</i> Wh            | nite  |                         |  |  |
| 72 ho<br>n "nat   | 2           | Completed                             | 15. Decedent's Edu<br>(Specify only highest grade   | completed)                          |              | (Give k            | ent's Usual Occup<br>ind of work done o<br>NOT use retired) | ation<br>during most of worki     | ng                         | 16b. Kind         | d of Business                 | Industry  |                         |  |  |
| within giene.   |             |                                       | Elementary/Seconday (0-12)  | College (1-4 or 5-<br>5+            | +)           |                    | reacher   |                                   |                            | Pub               | lic Ed                        | ucat  | ion                     |  |  |
| be filed vental Hyg<br>ked other<br>c event,  |             |                                       | 17. Father's Name (First, Middle, Last)   |                                     |              |                    |   | 18. Mother's Name                 | (First, Middle,            | Maiden Su         | rname)                        |   |                         |  |  |
| uld be<br>uld be<br>I Meni<br>marke<br>matic e  | F           |                                       |   | oke                                 |              | Troy               |   | Laura                             |                            |                   |                               | Beat  | ty                      |  |  |
| 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  1 and 2 should be a should be a should be a shown other traumatic event, the Medical Examiner must be notified at |             | -1                                    | 19a. Informant's Name/Relationship (Type<br>Herbert Williams –  |                                     | 1            |                    | -   | and Number or Rura                |                            |                   |                               | •   |                         |  |  |
| permit. Page 1 and 2<br>Department of Healt<br>Important: If item 2<br>any injury or other  |             |                                       | 20a. Method of Disposition  | <del>-</del>                        | 20b. Pla     | ace of Dispos      | sition (Name of<br>atory or other place                     | niell, Hel                        | oate Ma                    |                   | ation - City or               |   | ate                     |  |  |
| Definition Page 1 Department of mportant: If it in any injury or o  |             |                                       | 1 X Burial 2 ☐ Cremation 3 ☐ R<br>4 ☐ Donation 5 ☐ Other (Specify)  | emoval from State                   | 1            |                    | Cemetery  |                                   | -2012                      | Sali              | sbury,                        | Mar   | yland                   |  |  |
| Depart<br>Depart<br>Import  | 100         | 1                                     | 21. Signature of Funeral Service Lice/Isee  | , RA                                | ha           |                    | Name and Addres   |                                   | unds Fu                    |                   |                               |   | 01007                   |  |  |
| 10  |             | +                                     | 23a, Bart 1, Enter the disease, or compli   | tions that caused                   | the death.   |                    |   | n Street,<br>g, such as cardiac o |                            |                   | Maryl                         |   | 218U4<br>eximate        |  |  |
| Ph iin  | 1           | - 4-                                  | 23a. part 1. Enter the disease, or complishock, or heart failure. List only of limmediate Cause (Final disease or condition | cause on each line                  | A            | rest               |   |                                   |                            |                   |                               | Interv  | al Between<br>and Death |  |  |
| Medica<br>Examine   | al          |                                       | resulting in death)   | Due to (or as a                     |              |                    | ,   |                                   |                            |                   |                               |   |                         |  |  |
| LAdiiiile   | •           | ,                                     | Sequentially list conditions,   | Due to (or as a                     |              | A                  |   |                                   |                            |                   |                               |   |                         |  |  |
| ted<br>Insit  | Fyaminer    | 1                                     | if any, leading to immediate Cause (Disease or iinjury  | Due to (or as a                     | conseque     | ince or):          |   |                                   |                            |                   |                               |   |                         |  |  |
| cate be executed physician and the burial-transit   |             |                                       | that initiated events cresulting in death) Last   | Due to (or as a                     | conseque     | nce of):           |   |                                   |                            |                   |                               |   |                         |  |  |
| ate be ohysici  | Pedical     |                                       | G d   |                                     | -            |                    |   |                                   |                            |                   |                               |   |                         |  |  |
|   |             |                                       | F FEMALE: 23  | c. If yes, outcome o                | of pregnance | су                 |   |                                   |                            | 22                | J Date of Jel                 |   |                         |  |  |
| requires that the death certific<br>been signed by the attending<br>should be detached for use as   | Physician/M |                                       | in the past 12 months?  1  Yes 2 No   | 1 Live Birth 2 4 Pregnant at        | 2 🗀 Fetal (  | death 3 🗌          | Ectopic pregnance Other (specify)                           | у                                 |                            | 23                | d. Date of del<br>Month       | Day   | Year                    |  |  |
| t the d<br>by the   | Phys        | -                                     | g ∐ Unknown   | 9 L Unknown                         | , , ,        |                    |   |                                   |                            |                   |                               |   |                         |  |  |
| es tha<br>signed  | ٤           | ֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓ | Part II. Other significant conditions conf  | nbuting to death bu                 | it not resul | ung in the ur      | ideriying cause <b>g</b> iv                                 | en in Part I.                     |                            |                   | contribute to                 |   | e of death?             |  |  |
| v requires<br>been signatures<br>should to  | Completed   |                                       |   |                                     |              |                    |   |                                   | 24a. Was a                 |                   |                               |   | lings available         |  |  |
| The law<br>cate has   | 1 2 2       | -                                     |   |                                     |              |                    |   |                                   | autop<br>perfor            | sy<br>med?        | prior to death?               | ompletio  | n of cause of           |  |  |
| ician; The<br>certificate<br>rector, pag  | PA C        |                                       | 25. Was case referred to medical examiner?  |                                     |              |                    | 26. Pla   | ace of Death (Check               | 1 \(\superset \text{Yes}\) | 2 US NO           | 1 🗌 Yes                       | ZLIN  | 0                       |  |  |
| hysician;<br>this certific<br>al director,  | <u>ا</u>    | 2                                     | 1 Yes 2 No  |                                     |              | R/Outpatient       |   | 4 L Nursing Hor                   |                            |                   |                               | fy) Ass   | st. Livi                |  |  |
| ding F<br>th.<br>After<br>funer   | late 2      |                                       | 17. Manner of Death  1 Natural 5 Pending 2 Accident Investigation   | 28a. Date of injury<br>(Month, Day, |              | 8b. Time of injury | 28c. Injury<br>work'<br>M 1                                 | rat<br>?<br>Yes 2 □ No            | 8d. Describe h             | ow injury o       | ccurred                       |   |                         |  |  |
| Atter<br>er dea<br>ector  | Certificate |                                       | 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of Injur                 | y - At hom   | ne, farm, stre     |   |                                   | 28f. Location (S           |                   | lumber or Rur                 | al Route  | Number,                 |  |  |
| To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director: After this completed filled in by the funeral di  |             |                                       |   | building, etc.                      |              |                    |   |                                   | City or Town               |                   |                               |   |                         |  |  |
| Hosp<br>24 hou<br>Fune  | Medical     | 2 2                                   | 29a. Certifier 1 Certifying Physic (Check 2 Medical Examine   | r: On the basis of ex-              | amination a  | and/or investi     | gation, in my opinio  | n, death occurred at              | the time, date ar          | nd place, an      | nd due to the d               | ause(s) ar  | nd manner stated.       |  |  |
| Fo the within Fo the comple   | Σ           |                                       | only one) 3 Certifying Nurse  | Practioner: To the b                | est of my k  | rnowledge, de      | 29c. License  |                                   |                            |                   | nd manner as<br>signed (Month |   | ar)                     |  |  |
|   |             |                                       | Lourenno P  | Thom!                               | A. ed        | M                  | D43   | 3914                              | `                          | 4/                | 19/20                         | 7/2   | _                       |  |  |
| 100   |             | 3                                     | 00. Name and address of person who cor  | / /                                 | ath (Item 2  | Sa) (Type, Pr      | int)  |                                   | (1)                        |                   | 111                           |   | /                       |  |  |
| - 21  |             | 3                                     | 1. Date filed (Month, Day, Year)  | OM DETTON<br>32 Registrar           | 's Signatur  | DD E.              | Carrol  | 15t, S                            | alisbur                    | -y ,              | m                             | ×18   | 01                      |  |  |
| St  | ate         | ,                                     | A DD 9 9 2 2011   |                                     | o orginalui  | 1                  |   | ,                                 |                            | / /               |                               |   |                         |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 05 **Physician** Elio A. Valerio 01 2012 12:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 19 Bealls Lane Frostburg Allegany Sex. 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-10-1929 Birthplace (State or Foreign Country) 231-23-2259 Months Days Hours Min. Milan Italy 82 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Frostburg Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 21532 10g. Citizen of What Country? 19 Bealls Lane U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Graphic Designer Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonida Valerio ٥ Maria Cirella Valerio 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Maria Valerio <u> 19 Bealls Lane Frostburg, MD 21532</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Cumberland Crematory 05-05-2012 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sowers Funeral Home, Frostburg, MD 21532 60 W. Main Street MOD 54 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Failu Immediate Cause (Final IVER disease or condition resulting in death) MO to (or as a consequence of) enal tai MO Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last circlesis of liver Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? p Completed 2**V** No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \sum Nursing Home ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation Natural N/A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

be executed Box 68760. death certificate P.O. Division of Vital Records, Physiclan:

attending physician and for use as the burial-tran s been signed by the s should be detached certificate has page 2 s After this funeral or Attending ours after death.

neral Director: A
filled in by the fu death. To the Hospital o within 24 hours af To the Funeral D completely filled in

Funeral

Director

28a-f show

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examination to once.

**Physician** 

/Medical

Examiner

Maryland 21215-0036

altimore,

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

and manner stated

CRNP 600 Memorral

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Ave Suite 30)

Cumbeland MDZISOR

State Registrar

Medical

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jahcori Maurice Whitley Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Juhns HODKINS HUSPITAL altimore Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Yrs Director 04/14/201 Usual Res dence of Decedent 28a-f show 10b. County 10a. State within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location Director Maryland Wicomico Salisbury 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1113 Nokomis Ave. 21801 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 10 Black, White, etc. þ 1 K Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the nla n a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alesha W. Carter Cameo M. Whitley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alesha W. Whitley/Mother permit. Page 1 and 2 sl Department of Health a Important: If item 27 is 1113 Nokomis Ave., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 20 1 Burial 2 X Cremation 3 Removal from State injury o 4 Donation 5 Other (Specify) Salisbury Crematory 4/17/2012 Salisbury, MD 21. Signature of Fuperal Service <sup>22</sup> Name and Address of Facility
Stewart Funeral Home by Holloway and Downey, P.A.
821 West Rd., Salisbury, MD 21801 any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death signed by the a 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No Records, Completed 1 Yes 24a. Was an certificate has page 2 autopsy perform Physician: The Yes 2 25. Was case referred to medical examiner? Division of Vital funeral director. Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes မ ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at Hospital or Attending Natural
Accident
Suicide iniury work? 1 \( \text{Yes} \) 2 \( \text{No} \) 5 Pendina Μ Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🔲 To the I within 2 To the I only one 29b. Signature and title of certi ed cause of death (Item 23a) (Type, Print) use ND

23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, 29d. Date signed (Month, Day, Year) 21287 600 North Was

Year

545A M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Interval Between

Onset and Death

1 Yes 2 X No

Maryland

Black

Registrar

State

Registrar's Signature

Registrar DHMH 17 Rev 06-2011

State

Box 68760

P.O.

PRIVE PREDCULLY MY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May 1 Wilson Roy <u>Jim</u> 11:30 AM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death <u>14406 Bender Lane</u> Cumberland Allegany 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth Months Aug 553-56-3030 Usual Re 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14406 Bender Lane 21502 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 X Married 2 🗌 No 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Vietnam white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>ibrarv Technician</u> Library of Congress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Wilson Bernice Tallmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mellie Wilson MD 21502 wife 14406 Bender Lane Cumberland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔲 Burial 2 🗆 🔀 mation 3 🗆 Removal from State 5/2/2012 Scarpelli Funeral Home, P.A. 4 Donation 5 D ther (Specify) Cresaptown MD of Funeral S 22. Name and Address of Eacility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) Due to (or as a consequence of): Millepedenie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consiquence of) event RIT arb Due to (or as a consequence of) resulting in death) Last 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Pregnant at time of death Month 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 ☐ Unknown 1 Yes

Physician/ Medical **Examiner** 

-transit

and

signed by the a

Jas

After this certificate

Division of Vital Records, P.O. Box 68760

Physician/

Medical

Director

Funeral

Completed by

Be

ပ

Examiner

**Funeral** 

Director

must be notified · 28a-f

5

permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 2% any injury or other traumatic event, the Madical Action Once.

Examine physician a s the burial-Physician/Medical as þ Completed page 2 should Be 은

Certificate:

25. Was case referred to medical examiner? 27. Manner of Death

the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? g Unknown

2 No

1 🗌 Yes

Natural

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

(Check

29b. Signature and title of certifie

Accident

Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year)

5 Pending Investigation 6 Could not be determined

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

1 🗌 Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Other:

28c. Injury at

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ROS4699- MD

26. Place of Death (Check only one)

2 🗌 No

24a. Was an

autopsy performed? Yes 2 No

4 Nursing Home 5 Residence 6 Other (Specify)

City or Town, State)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kuy Starvey

19912 Seton

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Walter Emil Arps, Jr. May 5, 2012 1320 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 1 🏝 M 2 🗆 F 146-24-6164 80 Aug. 4, 1931 New Jersey Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location Director MD Anne Arundel Annapolis 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 220 Claude Street 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 € Yes 2 □ No If Yes, Give Year or Dates. 1953–55 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Wildowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Editor Publishing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Emil Arps, Sr. Adele L. Hebeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adrienne B. Banks / sister 1573 Fulham Street St. Paul, MN 55108 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or cemetery, crematory or other place) 4 Donation 5 Other (Specify) Final Journey Crematory 5/8/12 Woodbine, MD 21. Signature of Funeral Service Going Home Cremation Service P.O. Box 784 any al M01651 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or Injury that initiated events the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 94 hours after death. Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ be detached for in the past 12 months? Pregnant at time of death Month Year 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed page 2 should 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available this certificate has autopsy prior to completion of cause of death? perform filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 - No 1 Yes မြ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Deatl 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 2-017 Mense State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ 2012 7:20 PM Lucien Amselli May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring 10605 Lester Street If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Director 577-04-0388 1 X M 2 D F Dec 30. 1927 Algeria 84 28a-f show at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Examiner must be notified 1 Yes 2 X No MD Silver Spring Montgomery ō 10e. Street and Number 10g, Citizen of What Country? 23a Funeral 10605 Lester Street 20902 France Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or. þ 1 Never Married 2 X Married 2 **X**No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Divorced Caucasian Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Flementary/Secondary (0-12) College (1-4 or 5+) Watchmaking 12 Watchmaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည marked Julie Elbaz Samuel Amselli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 27 Amselli / Wife 10605 Lester St. Silver Spring, MD 20902 Simone 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 05/09/12 4 Donation 5 Other (Specify) Journey Crematory Woodbine, Maryland f Funeral Service Li Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M Beverly L. Heckrotte, P.A. MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death

year Physician/ Prostate Cancer disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 phy attending pl IE FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 X No prior to completion of cause of death? 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital 2 XNn Other: ည 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending after death.

Director: Aft 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the base of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29c. License number May 7, 2012 D09834 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MDPA 3720 Farragut Ave. Kensington, MD 20895 Barry Rosenbaum, State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month reuton Absalom Daneilio 16:33 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mercy Medical Center Baltimore Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreig Country) **Funeral** Year) 110 Director N/A 30 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No MO Hen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or Funeral USA 21061 ve items ( 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iten edical Examiner r Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Daneilio Christoplas salom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renesha Absalon 20a. Method of Disposition 302 MD 21061 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Baltimere a Bradley ASKON FUNERAL 22. Name and Address of Facility Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Drematuriti xtreme disease or condition Medical resulting in death) Due to (or as a consequence of) 4hours Examiner from viability Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial-To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 2 X No ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Investigation Accident completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) MU 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD, 21202 Paul Place. Date filed (Month State MAY 1 0 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month, Physician/ Day Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Annapolis Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min Director 123-26-8685 1 ፟፟፟X M 2 □ F 76 Yrs Dec 16, Maryland show at 10a. State 10c. City. Town or Location the Maryland 10d. Inside City Limits Director must be notified 28a-f 1 Yes 2 No MD Anne Arundel Odenton 10e. Street and Number 'n 10f. Zip Code 10q. Citizen of What Country? Funeral 23a 608 Rolling Hill Walk 21113 IISA #102 "natural", or items idical Examiner mu death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. white Specify: 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 musician entertainment and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Arthur E. Anderson Martha Gyland traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trau Martha L. Anderson/spouse 608 Rolling Hill Walk #102 Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street xector Baltimore, ΜĎ 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami and use as the burial-trar resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy be detached for in the past 12 months? Pregnant at time of death Other (specify) Month Day Year 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 2 🗷 o 3 🗆 Probably 4 🗀 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law hin 24 hours after death.

the Funeral Director: After this certificate has later than the Funeral Director. performed? Yes 2 2 🗌 No 1 🗌 Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ျှ 1 Tes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2 To the I only one) 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number

Registrar

Parl

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 11:00 a M WINIFRED ALLEN May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGES CO. 12600 MEADWOOD DR. SILVER SPRINGS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB 23 1 9. Birthplace (State or Foreign Social Security Numbe 6. Sex . Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Days Hours SAMACIA **Director** 98 10-42-2812 Usual Residence of Decedent show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No MARYLAND PRINCE GEORGES SILVER SPRINGS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12600 MEADWOOD DR. 20904 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death be Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc Completed by 1 Never Married 2 Married Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: BLACK 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOSPITAL NURSING ASST. 12yrs lyr Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ADELINE THOMAS JOHN KELLY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 216 SHAWNEE RD., ARDMORE, PA., 19003 ORVIN K. ALLEN/SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 XOther (Specify) ENTOMB WEST LAUREL HILL 05/22/12 LOWER MERION, PA. 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVE., BALTIMORE, MD., 21217 Moun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (das a consequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 month 1 Yes 2 Vo Month Year Other (specify) Day Pregnant at time of death 1 Yes 2 g signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Be Completed should peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 has autopsy 2 No After this certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? 2 No Hospital: Other: ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural iniurv 5 Pending Accident Investigation completed filled in by the 24 hours after deal Funeral Director 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2 only one) 29b. Signature and title of cert)f 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar CITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 1 perpHYS# 10b, perFH, G927, 5/15/2012, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month Physician/ 8 2012 4:47 Edward Ρм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne **Examiner** Howard Arunde1 7810 Clark Rd., Lot D62 Jessup Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Age (In vrs. last birthday) **Funeral** <sup>Yea</sup> 1<u>935</u> Country) Virginia Oct. 11 1 X M 2 □ F Hours 216-32-1692 76 **Director** Usual Residence of Decedent show 10b. County 10d, Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Anne Arundel 3a or 28a-f sh t be notified a 1 ☐ Yes 2 XNo Maryland Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a e Funeral 7810 Clark Road, Lot D62 20794 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 XWidowed 4 ☐ Divorced Year or Dates 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Clerk Grocery Store n and Mental Hygier 7 is marked other t Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. Robey Wayne Bray Laura Margaret Lyons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kennard Ayers/Step-Son P.O. Box 2721, Brooklyn, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Metro Crematory Inc. 05/10/2012 | Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Euneral Service License Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Lath Immediate Cause (Final Physician/ Edema disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** pertensi 100 Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed tchaccs Due to (or as a consequence of): resulting in death) Last Physician/Medical disease aiten CICRONY Division of Vital Records, P.O. Box 68760 attending pl 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE. 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of has le 2 autopsy page death? Yes 2 No 1 ☐ Yes 2 ☐ No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Hospital: ၉ 1 U Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury ■ Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 5-10-12 naus 10 1) 00 16964 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6300 Strens Fourt Ad Colube Md Howard (our to THEN 32. Registrar's Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  |   |                  | For<br>State<br>Registrar  |                                | State of   | Marylan                         |  | artment of H<br>tificate of L   |                                      | d Mental Hy  | Ü                           | 2012   | 11.831   |
|--|---|------------------|--|--------------------------------|--|---------------------------------|--|---|--------------------------------------|--|-----------------------------|--|--|
|  | Physicia  | in/              | 1. Decedent's Name   | e (First, Middle,              | Past)  | <u> </u>                        | 061                                    | incate of L   | Jean                                 | 2. Date of De  |                             | Year   | 3. Time of Death                                   |
| 0  | Medic<br>Examir   |                  |  |                                | give street and numb<br>ngton Med.   |                                 | or                                     | 4b. City, Town, or Glen B   |                                      | May 4  | 4c. C                       | 12<br>County of Death<br>Anne Aru                  | 6:45 P <sup>M</sup>                                |
|  | Funeral<br>Director   |                  | 5. Social Security Nu<br>180–22–52   | umber (                        |  | . Age (In yrs. Id               |  | If Under 1 Year<br>Months Days  | If Under 24 H                        | #rs. 8. Date of Bit (Month, Date 5/11/   | rth                         |  | place (State or Foreign<br>try)                    |
| New York   | 8a-f show   | rector           | Usual Residence of 10a. State  | 10b. County                    | imore  |                                 | y, Town or Loc                         |   | <u> </u>                             |  |                             | 1  | 0d. Inside City Limits 1 ☐ Yes 2 XNo               |
| with the   | is 23a or 2<br>nust be no   | Funeral Director | 10e. Street and Num 5403 Per   |                                | venue  | <u></u>                         |  | 10f. Zip Code 21207   |                                      |  | 10g. Citize                 | en of What Cour                                    | ntry?  |
| )036   | Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | <u>ام</u> ا      | 11. Marital Status 1 ☐ Never Marri 3 ★Widowed  |                                | 12. Was Decede<br>Armed Forced<br>1  Yes 2<br>If Yes, Give<br>Year or Date | es?<br>2 💢 No                   | If                                     | /as Decedent of Hi<br>Yes, specify Cuba<br>☐ Yes 2X No                |                                      | (Specify Yes or No-<br>lerto Rican, etc.)  |                             | 4. Race - Americ<br>Black, White, of<br>pecify:    |  |
| Baltimore, Maryland 21215-0036   | giene.<br>er than "nate, the Medica   | Completed        | (Specentary/Seco   |                                | s Education<br>t grade completed)<br>College (1-4                          | or 5+)                          | (Give k                                | ent's Usual Occup<br>ind of work done of<br>NOT use retired)<br>naker | ation<br>during most of v            | working  | 16b. Kind                   | d of Business/Ind                                  | ,  |
| yland<br>Id be filed   | Mental Hyginarked oth   | To Be            | 17. Father's Name (F<br><b>John</b>  | irst, Middle, La<br>Brown      | st)  |                                 |  |   |                                      | Name (First, Middle,<br>rie Franc  |                             | urname)  |  |
| e, Mar   | Health and<br>Health and<br>Her traum   | 199              |  | . Bradf                        | o (Type, Print) ord / Son  |                                 | 3 G:                                   | llmore St   |                                      | Rural Route Numbe  |                             |  |  |
| Itimora<br>it. Page 1.   | intment of h  |                  | 4 Donation   | ☐ Cremation 3<br>5 ☐ Other (Sp |  | tate C                          | emetery, crem<br>odlawn                | ition (Name of<br>atory or other plac<br>Cemetery                     | 5,                                   | Date<br>/9/2012  | Gwyn                        |  | Maryland   |
| Ba   | Depar<br>Impor<br>any ir  |                  | 21 Sinner are of Fun   | کرر                            | No.  |                                 | 4                                      | Name and Addres   | ens Aver                             | Hubbard<br>nue, Balt   | imore                       | al Home,<br>Maryla                                 | , Inc.<br>and 21229                                |
|  | y ician<br>Medical  |                  | 23a. Part 1. Enter the<br>shock, or heard<br>Immediate Cause (F<br>disease or condition<br>resulting in death) | t failure. List on<br>Final    | omplications that cau<br>y one cause on each<br>a.                         | line.                           | Λ.                                     | the mode of dying   |                                      | liac or respiratory ar   | rest,                       |  | Approximate<br>Interval Between<br>Onset and Death |
|  | xaminer   | Examiner         | Saqueritally list conif any, leading to imposure. Enter Underlause. Clisease or in that initiated events       | mediate<br>ying<br>njury       | Due to (or   | as a consequ                    | ence of):                              |   |                                      |  |                             |  |  |
| 60<br>ate be exec  | hysicia<br>the buri   | dical            | resulting in death) L  | ast                            | Due to (or   | as a consequ                    | ence of):                              |   |                                      |  |                             |  |  |
| Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate be executed | signed by the attending pl<br>d be detached for use as t  |                  | F FEMALE:<br>23b. Was decedent p<br>in the past 12 m<br>1  Yes 2  9  | onths?                         |  | th 2 🗌 Fetal<br>nt at time of d | Ideath 3                               | Ectopic pregnanc<br>Other (specify)                                   | у                                    |  | 23                          | 3d. Date of delive<br>Month                        | ery<br>Day Year                                    |
| rds, P.O   | een signec<br>hould be d  | þ                | Part II. Other signific  | cant conditions                | s contributing to deat   | th but not resu                 | ulting in the ur                       | derlying cause giv  | en in Part I.                        |  |                             |  | e cause of death?                                  |
| al Reco  | ate has<br>page 2   | Be Completed     | 25. Was case referred  | d to medical                   | T  |                                 |  | 26 Pla  | ce of Death (C                       | 1 Tes  | osy<br>ormed?               | 24b. Were autop<br>prior to con<br>death?<br>1 Yes | osy findings available inpletion of cause of       |
| n of Vita  | 18 5 I  | ျှ               | examiner?  1 Yes 2 2  27. Manner of Death  1 Natural 2 Accident  | No 5 Pending Investigat        | 28a. Date of (Month,   |                                 | R/Outpatient<br>28b. Time of<br>injury | 3 DOA Othe  | r: 4 🗀 Nursing                       | g Home 5 Resident Res |                             |  |  |
| Divisio  | urs after dea<br>ral Director:<br>Illed in by the   | al Certificate:  | 3 Suicide<br>4 Homicide  | 6 Could no determine           | t be<br>28e. Place of<br>building,   | etc. (Specify)                  |  | et, factory, office   |                                      | City or Tow  | n, State)                   | Number or Rural i                                  |  |
| the Hosp   | within 24 hours a  To the Funeral C  completely filled  | Med              | (Check 2 L   | Certifying N                   | hysician: To the best<br>miner: On the basis ourse Practitioner: To        | of examination                  | and/or investig                        | ation in my opinior   | n, death occurre<br>e time, date and | ed at the time, date a<br>d place, and due to the  | nd place, an<br>he cause(s) | nd due to the cau<br>and manner as st              | se(s) and manner stated.<br>lated.                 |
| • P  | <b>Σ</b> Ε δ  |                  | · //   | 1an'                           | Bull of completed cause of   | of death /Home                  | 23a) /Time D                           | D00   | ( Y Y S                              | 4  | 29d. Date s                 | 7/12   | ray, Year)   |
| 5  | State   |                  | ( ) 19   | 12 ( )                         | 32. Regi   | rar's                           | Sale (Type, Pri                        | 03 B  | 2/4m                                 | of m   | 7 77                        | 215  |  |
| /  | Registra  | r                | MAILU  | ZUIZ A                         | en ,   |                                 |  |   |                                      |  |                             |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Baker 2012 MAy 9, 1:00 Ам Howard Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Dundalk 7810 St. Fabian Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 163-22-2039 **Director** 1**X** M 2 □ F Yrs Klandika, Maryland December 2,1927 84 Usual Residence of Decedent or 28a-f show iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dundalk Maryland Baltimore 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral be filed within 72 hours after death with 21222 USA 7810 St. Fabian Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 12. Yes 2 No If Yes, Give 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", 3 Widowed 4 Divorced Specify: White Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Bethlehem Steel Foreman 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lorretta Compton Edward O. Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21222 19a. Informant's Name/Relationship (Type, Print) 7810 St. Fabian Lane, Dundalk, MAryland wife Myrtle Baker 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May Date 0, 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory Baltimore, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License onnelly Funeral Home Of 1110 Sollers Point Road, Dundalk, P.A. Dundalk, Maryland 21222 23a. Part 1. Enter the disease shock, or heart failure. U or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician/ CAS disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** uears 01 DNATU Sequentially list conditions, Examine if any, leading to ininieulate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on the burial-transi and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ signed by the atter in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown completely filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has autopsy performed Ves 2 No 2 No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No M Accident Investigation 2 Accident
3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and ti e of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOMAS FINUCA

DHMH 17 Rev 06-2011

State

Registrar

1 0 2012

32. Registrar's Signature

|                            |   |                               | Please Type or Pr<br>amend #17&18 Per EH<br>State of V   | int in Black<br>G929 7/1<br>laryland / D              | k Indelible Ink<br>7/2012 JH<br>epartment of H                                 | . Ensure A<br>ealth and M                    | II Copies A<br>Iental Hygiei                   | re Leg<br>ne               | jible.   |                                       |                     |
|----------------------------|---|-------------------------------|--|---|--|--|--|----------------------------|--|---------------------------------------|---------------------|
|                            |   | •                             | For State State Registrar  |   | Certificate of D   |  | Reg.   | 2                          | 013  | 2 14                                  | 836                 |
|                            | Physicia<br>Medic   |                               | 1. Decedent's Name (First, Middle, Last)   | GUM   |  |  | 2. Date of Death                               | Pay 2                      | 012  | 3. Time of 3.30                       |                     |
|                            | Examin  |                               | 4a. Facility Name (if not institution, give street and number) 5355 Horpers Form   | Road  | 2 4b. City, Town, or   | Location of Death                            |  | 4c. County                 | of Death   | e)                                    |                     |
|                            | Funeral<br>Director   |                               | 215-63-007 1 1 M 2 M F   | ge (In yrs. last birtho                               | day) If Under 1 Year<br>Months Days  | If Under 24 Hrs. Hours Min.                  | 8. Date of Birth                               | 2                          | 9. Birth   | place (State or                       | Foreign             |
|                            | ryland<br>-f show<br>ied at   | ctor                          | Usual Residence of Decedent  10a. State  10b. County   | 10c. City, Town o                                     | or Location  |  |  |                            |  | 10d. Inside Cit                       |                     |
|                            | ith the Ma<br>3a or 28a<br>t be notif   | ral Director                  | 10e. Street and Number   | Docat #   | 2 10f. Zip Code  |  | 10g.   | Citizen of                 | What Cou   |                                       | 2 🗆 NO              |
| 336                        | nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artement of Heath and Mental Hygiene. ortant: If time 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.e.  | d by Funeral                  | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Armed Forces 1 Never Married 2 If Yes, Give Year or Dates,  | ?/  | 13. Was Decedent of His If Yes, specify Cubar                                  | , Mexican, Puerto I                          | cify Yes or No-<br>Rican, etc.)                |                            | ck, White,   | can Indian,<br>etc.                   |                     |
| 21215-0036                 | vithin 72 hours<br>iene.<br>ir than "natur<br>the Medical I   | Completed                     | 15. Decedent's Education (Specify only highest grade completed)  Elementary Seconday (0-12)  College (1-4 or   | ((  | Decedent's Usual Occupa<br>Give kind of work done do<br>fe DO NOT use retired) | tion<br>uring most of working                | ոց 16է   | o. Kind of B               | usiness In   | ndustry                               |                     |
| 0                          | should be filed wand Mental Hygi<br>r smarked othe<br>raumatic event, i   | اما                           | 17. Father's Name (First, Middle, Last) Allah Di   | itta  |  | 18 Mether 12                                 | Girst, Middle, Maid                            | en Surnam                  |  |                                       |                     |
|                            | and 2 shoul<br>Health and I<br>tem 27 is ma   | 7                             | 19a, Informant's Name/Relationship (Type, Print)   | 53  | Mailing Address (Street a  | nd Number or Rura.                           | FARM   | RI) (                      | olu  | ubia,                                 | MD                  |
| Baltimore,                 | permit. Page 1 and<br>Department of Hea<br>Important: If item<br>any injury or other  |                               | 20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)   |   |  | 5-8  | -2012 L  | Location AUD               | - City or To   | own, State                            |                     |
| Ba                         | permit<br>Depar<br>Impor<br>any in  | 3                             | 21. Signature of Funeral Service Licensee  | uh.   | 22. Name and Address   | foeD.  | Road E   | essi                       | JP, h  | D 207                                 | 74                  |
|                            | hy i ian<br>Medical<br>Examiner   | 100                           | 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lir Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as   | ed the death. Do not<br>ne. S U<br>s a consequence of | Lerotic C  | ardio Va                                     | r respiratory arrest,                          | De                         | 200  | Approximate Interval Betwoonset and D | veen                |
| 12                         | executed in and ial-transit   | Examiner                      | If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events   | s a consequence of)                                   |  |  |  |                            |  |                                       |                     |
|                            |   | l I                           |  | s a consequence of)                                   | ):   |  |  |                            |  |                                       |                     |
| P.O. Box 68760             | for the Hospital or Aftending Physician: The law requires that the death certificate be exwithin 24 burns after death.  Within 24 burns after death.  To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial | Completed by Physician/Medica |  | 2 Fetal death at time of death                        | 3  | 1  |  |                            | ate of deliv   | - /                                   | ear                 |
| ls, P.O                    | uires tnat ti<br>n signed by<br>ild be deta   | ed by P                       | Part II. Other significant conditions contributing to death  |   | the underlying cause give  | en in Part I.                                | 23e, Did tobaco                                |                            |  | he cause of debably 4 🗆 l             |                     |
| Division of Vital Records, | ne law requ<br>e has beer<br>age 2 shou   | omplete                       |  |   |  |  | 24a. Was an autopsy performed                  | _                          | Were auto<br>prior to co<br>death?<br>1 \( \sum \) Yes | opsy findings a                       | vailable<br>ause of |
| tal F                      | cian: 1<br>ertifical<br>ector, p  |                               | 25. Was case referred to medical examiner?   |   |  | ce of Death (Check                           |  | NO                         | I L Tes  | 2 125010                              |                     |
| of Vi                      | Physic<br>rthis c<br>eral dire  | 잍                             | 1 ☐ Yes 2 ♠ No 1 ☐ Inpat  27. Manner of Death 28a. Date of inji  |   | me of 28c. Injury  | 4 LI Nursing Ho                              | me 5-X Residence<br>28d. Describe how in       |                            |  | y)                                    |                     |
| sion (                     | ttending<br>death.<br>stor: Afte<br>/ the fune  | Certificate:                  | 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be  |   | ury work?  | /es 2 □ No                                   | 28f. Location (Street                          |                            |  | of Doute Numb                         |                     |
| Divis                      | To the Hospital or Attending Physician: The law within 24 Hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.  |                               |  | tc. (Specify)   |  |  | City or Town, St                               | ate)                       |  |                                       | 31,<br>             |
|                            | <b>To the Hos</b><br>within 24 h<br><b>To the Fun</b><br>completed  | Medical                       | (Check 2 ☐ Medical Examiner: On the basis of only one) 3 ☐ Certifying Nurse Practioner: To the   | examination and/or i                                  | investigation, in my opinior<br>dge, death occurred at the                     | n, death occurred at<br>time, date and place | the time, date and place, and due to the cause | ace, and du<br>se(s) and m | ie to the ca<br>anner as s                             | ause(s) and mar<br>tated.             | nner stated.        |
|                            | o o wir   |                               | 29b. Signature and title of certifier  | tu  | M . \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \  | 2472   | .\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \         | AY                         | 8 ix   | Day, Year)                            | 12                  |
| _                          | 2   |                               | 30. Name and address of person who completed cause of Cause | 4333 Le   | rpe, Print) rul Bow  | c Rd.  | 5+208  | LA                         | lfEL   | m                                     | 20708               |
|                            | Stat<br>Registra  |                               | 31. Date Med Worth, Asy 2012 Service 32. Registr   | raje Signa  |  |  |  |                            |  | ,                                     |                     |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 7, Physician/ Brooks Dorothy 2012 9:30a M May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sykesville Carroll Co. Senior Constant Care If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral Director** 219-14-1238 1 M 2x F 95 Vrs Apr15,1917 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified Dundalk Md. Baltimore 1 🗆 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be r Funeral 21222 3117 Yorkway U.S.A. items permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene.
Important: I fitem 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8th Cleaning Cleaning Be 17. Father's Name (First, Middle, Last) (unk) 18. Mother's Name (First, Middle, Maiden Surname) (unk) ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald L. Brittingham/son |3117 Yorkway Dundalk, Maryland 21222 Sob Place of Jisposition (Name of Serffeter), crematory or other place) 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State May Date Heart of JesusCem | 11, 2012 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, MD 21222 1201 Dundalk Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onse and Death Immediate Cause (Final Cholecysti Physician/ renous disease or condition resulting in death) Medical Due to (or as a consequence of: Examiner Sequentially list conditions Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury attending physician and d for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. From the speen signed by the attending physicial Funeral Director. After this certificate has been signed by the attending physicial P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown 5 Other (specify) Month Day Year the g 🗌 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes After this certificate has been significate has been significated and a should be shou Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 M Nursing Home 5 - Residence 6 - Other (Specify) Hospital 1 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 5 Pending iniury X Natural work?
1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 To the I within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year) D 33681 May 8, 2012

DHMH 17 Rev 06-2011

State Registrar Michael McEvoy, M.D. 1380 Progress Way Suite 114

Eldersberg, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar 14838 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201 2 May Μ. Biedronski 4. 8:48A.M Frances Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Care Baltimore Towson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Dav. Year) 215-05-9545 91 Director 1 🗆 M 2 🔀 F 102/10/ Aug18,1920 Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location notified at Director 1 Yes 2 No Md. Nottingham Baltimore 05/ 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral U.S.A. 21236 4247 Darleigh Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Biedranski 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White Completed 3 🛭 Widowed 4 🗌 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) Crossing Guard City of Baltimore Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 0 Sieminski Frank Caroline Fuchs V 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Myers - Daughter 4247 Darleigh Road Nottingham, Md. 20b. Place of Disposition (Name of Sacred, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May Date 1 KBurial 2 Cremation 3 Removal from State 7, 2012 Baltimore, Maryland 4 Donation 5 Other (Specify) ofHeart JesusCem 21. Signature of Funeral Service Lice 22. Name and Address of Facilit Kaczorowski Funeral Home, PA M00933 201 Dundalk Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ULna Physician/ Fra 0 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): ending physician use as the burial Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) atten for u in the past 12 months?

1 Yes 2 No
9 Unknown the a Unknown been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No has page 2 certificate or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOS P/Co Hospital: 2 No ုဝ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 Natural 2 Accident 5 Pending 04/27/2012 hn known M Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1440 WGL Than 184 vd 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined A5515Ted LIWING Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) Name and address of person Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MÃ George Carson Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death umbia orien 0 Howard Olumbia Social Security Numbe Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthplace Country) PA **Funeral** Hours Min. Nov 10, Director 195-22-3678 1 【XM 2 ☐ F 84 Yrs Usual Residence of Decedent 28a-f show ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2√√☐ No MD Howard Highland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7150 Brooks Road 20777 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, r than "natural", or ite the Medical Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 XDivorced Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Farmer/Herdsman Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F marked o ပ Frank Carson Margaret Logue 19a. Informant's Name/Relationship (Type, Print) (Daughter Mrs. Kathleen Levengard and is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra 7150 Brooks Road, Highland, MD 20777 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 DOther (Specify) All County Cremation 5/10/2012 Sykesville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) erebrovascular Medical Due to (or as a consequence of) Examiner rtension Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury mentia use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) ding physician Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown 9 Unknown Division of Vital Records, P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed? Yes 2 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 2 **N**Vo Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this funeral ( 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide М 1 Yes 2 No pletely filled in by the Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier P14855 person who completed cause of death (Item 23a) (Type, Print) olumbia 334

DHMH 17 Rev 06-2011

Registrar

ora

1 0 2012

32. Registrar's

edar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|   |  |                  | For State  | State of                            | Maryland                         | d / Depa<br>Cea               | artment of<br>tificate of                | Health a                           | and Mental H   | ygien<br>Reg. N         |  | 2 14840  |
|---|--|------------------|--|-------------------------------------|----------------------------------|-------------------------------|--|------------------------------------|--|-------------------------|--|--|
|   | Physicia   | n/               | Registrar  1. Decedent's Name (First, Middle, L  | .ast)                               |                                  |                               |  |                                    | 2. Date of I   | Death                   |  | 3. Time of Death                                   |
| in the state of                         | Medic<br>Examin  | al               | Hee Ja Chang  4a. Facility Name (if not institution, g.  | ive street and number               | er)                              |                               | 4b. City, Town,                          | or Location of                     | May May  |                         | 2012 Year 4c. County of Dea              | 2:50 PM  |
|   | Examin   | ler              | Greater Baltin   | nore Med                            | ical                             |                               | r To                                     | wson                               |  |                         | Baltim                                   |  |
|   | Funeral<br>Director  |                  | 5. Social Security Number 6. 215–76–1371   | . Sex 7.                            | Age (In yrs. la                  | st birthday)<br>Yrs.          | If Under 1 Yea<br>Months Days            |                                    | Min. (Month, I   | Day, Year               | ) Co                                     | rthplace (State or Foreign ountry)                 |
|   | ld<br>now<br>at  | Ļ                | Usual Residence of Decedent  10a, State  10b. County   |                                     |                                  | , Town or Lo                  | cation                                   |                                    | April  | 18,                     | 1944                                     | Korea  10d. Inside City Limits                     |
|   | //arylar<br>// 8a-f sh<br>tified a   | recto            | Maryland Howard  |                                     | 1                                | licott                        |  |                                    |  |                         |  | 1 X Yes 2 □ No                                     |
|   | th the N<br>3a or 2<br>t be no   | al Di            | 10e. Street and Number   | Court                               |                                  |                               | 10f. Zip Code                            | 21042                              |  | 10g. (                  | Citizen of What C                        | ountry?  |
|   | eath wi  | Funeral Director | 3639 Morningvie  | 12. Was Decede                      |                                  | . 13.                         | Was Decedent of                          | Hispanic Orig                      | in? (Specify Yes or N<br>Puerto Rican, etc.)                               | 0-                      | 14. Race - Am                            |  |
| 36                                      | after d<br>al", or i<br>xamin  | by               | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced   | d 1 Yes 2 If Yes, Give Year or Date | XNo                              |                               | 1 Tes, specify Cu<br>1 ☐ Yes 2 💢 N       |                                    | Puerto Filcari, etc.)  |                         | Black, Whi                               | sian   |
| 15-0036                                 | 2 hours<br>"natura<br>dical E  | Completed        | 15. Decedent's<br>(Specify only highest  | s Education                         | 5.                               |                               | dent's Usual Occi                        |                                    | of working   | 16b.                    | Kind of Business                         |  |
| $\mathcal{L}_{\mathcal{L}}$             | vithin 7:<br>liene.<br>er than<br>the Me   | Com              | Elementary/Secondary (0-12)  | College (1-4                        | or 5+)                           | life. D                       | o NOT use retire<br>elf Empl             | d)                                 |  | D                       | ry Clear                                 | ner  |
| Chang, He.                              | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | To Be            | 17. Father's Name (First, Middle, Las<br>Kyung Keun Ch   | ,                                   |                                  |                               |  | 18. Mothe                          | or's Name (First, Middle)<br>ong Yearn                                     |                         |  |  |
| 1901<br>Mary                            | 2 should<br>th and M<br>27 is mar<br>traumat   | b                | 19a. Informant's Name/Relationship<br>Man Hyung Chang  |                                     | d                                |                               |  |                                    | r or Rural Route Num   |                         |  |  |
| ha.                                     | of Heal  |                  | 20a. Method of Disposition  1    Burial 2 □ Cremation 3  |                                     | 20b. P                           | ace of Dispo<br>emetery, crer | sition (Name of natory or other p        | ace)                               | Date   | 20c.                    | Location - City o                        |  |
|   | artment<br>ortant:<br>injury o   |                  | 4 Donation 5 Other (Spe  | ecify)                              | Mea                              |                               |  |                                    | 05#07/2012<br>Gary L.  |                         | -  | Maryland   |
| Ва                                      | permit<br>Depar<br>Impor<br>any in   |                  | Libece   | 050                                 | MO12                             | 33 7                          | 250 Wasl                                 | ningtor                            | Blvd., E   | lkri                    | dge, Mai                                 | cyland 21075                                       |
|   | 1000 TO 1  |                  | 23a. Part 1. Enter the disease or co<br>shock, or heart failure. List only<br>Immediate Cause (Final | y one cause on each                 | line.                            | . Do not ent                  | er the mode of dy                        | ring, such as o                    | cardiac or respiratory   | arrest,                 |  | Approximate<br>Interval Between<br>Onset and Death |
| 0                                       | Phylician<br>Medical<br>Examiner   |                  | disease or condition resulting in death)   |                                     | as a consequ                     | ence of):                     |  |                                    |  |                         |  |  |
| 8.7                                     | LXammor  | ner              | Sequentially list conditions, if any, reading to immediate cause. Enter Underlying                   | b. Due to (or                       | as a consequ                     | ence c.j                      |  |                                    |  |                         |  |  |
| . J.                                    | cate be executed physician and s the burial-transit  | Examiner         | Cause (Disease or injury that initiated events resulting in death) Last                              | c                                   | as a consequ                     | ence of):                     |  | ··                                 |  |                         |  |  |
| 8                                       | ate be executed hysician and the burial-transi   | edical           |  | d                                   |                                  |                               |  |                                    |  |                         |  |  |
|   | ertificat<br>ding ph   | /Mec             | IF FEMALE:   | 23c. If yes, outco                  | me of pregna                     | acv.                          |  |                                    |  | _                       |  |  |
| Division of Vital Records, P.O. Box 687 | To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as             | Physician/M      | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown                           | 1 Live Bi                           | rth 2 ☐ Feta<br>Int at time of d | I death 3                     | ☐ Ectopic pregna☐ Other (specify)        | ncy                                |  |                         | 23d. Date of d                           | Day Year   |
| P.O.                                    | s that th<br>gned by<br>se detac   | 2                | Part II. Other significant conditions  | s contributing to dea               | th but not resu                  | ulting in the u               | ınderlying cause                         | given in Part I                    |  |                         | N  | to the cause of death?                             |
| rds,                                    | requires<br>been sig   | eted             |  |                                     |                                  |                               |  |                                    | 1 L  |                         |  | Probably 4 Unknown  utopsv findings available      |
| Reco                                    | The law rate has k   | Completed        |  |                                     |                                  |                               |  |                                    | au   | topsy<br>rformed<br>s 2 | prior to                                 | completion of cause of                             |
| /ital                                   | rsician:<br>s certific   | To Be            | 25. Was case referred to medical examiner?  1 \(\sum \) Yes \(2 \) No                                | Hospital:                           | patient 2 🗆                      | ER/Outnatie                   | La                                       | ther:                              | h (Check only one)   | eidanca                 | 6 Other (Spe                             | city)  |
| of/                                     | ing Phy<br>ifter this<br>uneral o  | ate: T           | 27. Manner of Death  1 X Natural 5 Pending   | 28a. Date of                        |                                  | 28b. Time o<br>injury         | 28c. Inj                                 | ury at<br>ork?                     | 28d. Describ   |                         | jury occurred                            | ony  |
| ision                                   | Attendi  | Certificate:     | 2 Accident Investigar 3 Suicide 6 Could no   | ot be 28e. Place of                 | f Injury - At ho                 | me, farm, str                 | M 1<br>eet, factory, offic               | Yes 2                              | 28f. Location  |                         |  | ural Route Number,                                 |
| Div                                     | oltal or<br>ours afte<br>eral Dire   |                  |  | building                            | , etc. (Specify,                 |                               |  |                                    |  | own, Sta                |  | totod  |
| 8                                       | To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2   | Medical          | (Check 2 Medical Exaconly one) 3 Certifying N  | aminer: On the basis                | of examination                   | and/or inves                  | tigation, in my op<br>, death occurred a | nion, death oc<br>at the time, dat | place, and due to the<br>curred at the time, dat<br>e and place, and due t | e and pla<br>to the cau | ice, and due to the<br>use(s) and manner | e cause(s) and manner stated.<br>as stated.        |
|   | Vor  |                  | 29b. Signature and title of certifier  Bluene  | a Jane                              | ters                             |                               | 29c. Licer                               | 729                                | 46   | 29d. [                  | Date signed (Mon                         | th, Day, Year)                                     |
|   | 10   |                  | 30. Name and address of person who BRIANA SANDE  | no completed cause                  |                                  | 23a) (Type, I                 | 0.6                                      | Bal                                | timoro   | mD                      | )  |  |
|   | Sta<br>Registr   |                  | 31. Date filed (Month, Day, Year)  | 32                                  | letrar's Signat                  | J.                            | ale                                      |                                    | .,,  |                         |  |  |
|   |  |                  |  | ,                                   |                                  | (1                            |  |                                    |  |                         |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201<sup>Yea</sup> John Carter May 04 Medical 3:40 am M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Citizens Care Center Havre de Grace Harford 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Country) Virginia 8. Date of Birth April 16,1934 Hours **Director** 215-30-1251 1 **X**□ M 2 □ F 78 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mater has a proper. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Harford Whiteford 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4125 McNabb Road 21160 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 2**X** No 1 ☐ Yes 2X No Specify. Completed 3 X Widowed 4 □ Divorced White Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Handyman Hote1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edgar Allen Carter Mary Evelyn Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4125 McNabb Road, Whiteford, Maryland 21160 Susan Mogavero- Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State
 ☐ Donation 5 ☐ Other Co. 20c. Location - City or Town, State Meadowridge Mem. Park 05/08/2012 Elkridge, Maryland Donation 5 Dother (Specify) 21. Signature of 7250 Washington Blvd uneral Service 22. Name and Address of Facility eDec M01283 Gary L. Kaufman Funeral Home Elkridge, Maryland 23a. Part 1. Enter the disease, o shock, or heart failure. List, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Due to (or as a com Examiner Sequentially list conditions Examine Due to or as a consequence of : if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-trar that initiated events resulting in death) Last Due to Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month 2 No 9 Unknown 9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signated I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of certificate has b lirector, page 2 s autopsy perform death? 1 ☐ Yes 2 🛂 25. Was case referred medical B 26. Place of Deat Check only one) examiner? Hospital: 2 No Other: 은 1 \rightarrow Yes 4 Kursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA After this the funeral 27. Marrier of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending injury Accident Investigation 1 Yes 2 No after death Director: Suicide Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and title of certifie

31. Date filed (Mo

DHMH 17 Rev 06-2011

State Registrar

rson who completed chuse of death (Item 23a) (Type Print)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

d (Month, Day, Year)

12-03538 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Michael Ciarpella State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month D May 7, 2012 1540 hrs **Medical Examiner** Michael Anthony Ciarpella, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex Funeral Months Days Min. Hours Director Dec. 29, 1982 217-02-9711 29 Country) Maryland 1 X M 2 F Yrs Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits PA Southern York New Freedom 1 Yes 2 X No death with the Maryland Director 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number 23a or 2 notified 17349 United States of America 15547 Revere Drive uneral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc. Armed Forces? 1 Never Married 2 Married Yes Specify: White and 2 should be filed within 72 hours after 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: \$ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) d other than Sanitation Worker Penn Waste 12 Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle, Last) Be Michael Anthony Ciarpella, Sr. Judy Ann Herring 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ို If item 27 15547 Revere Drive, New Freedom, PA 17349 Judy Ann Ciarpella - Mother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date filmore, 1 Burial 2 XXCremation 3 Removal from State Evars Fure and Cremation Services-Belair | May 12, 2012 | 4 Donation 5 Other Specify: Forest Hill, Maryland 22. Name and Address of Facility
22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services - Monkton
16924 York Road, Monkton Maryland 21111

Approximate shock of heart
Approximate 21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Methadone and Alcohol Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and AMENDED 23a, 27, 28a-f, per me, g927 5-16-12 sm tem #1 as noted, per me, g927 5-16-12 sm Physician/Medical X UNPENDED attending physician for use as the burial -Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the ? 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autoosy has death? performed? Yes 2 No 2 No page certificate 1 🗸 Yes 26. Place of Death (Check only one) of Vital 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA Other Nursing Home 5 Residence 6 Other this 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b Time of Injury 28c. Injury at Work? After Certification: 1 Natural 1 Yes 2 X No Division unknown Director: Pending fd 5-7-12 fd 15:00 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2737 Miles Ave. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide determined To the Funeral 4 Homicide (Specify) Single Family Home Baltimore.MD. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

O.C.M.E.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

**ORIGINAL** 

May 8, 2012

1 pend

OCME

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD

32. Registar's Signature

d 11

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month-Physician/ Martin 0118 M Henry Clark Jr. 08 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Agnes Haspiter Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213-68-8091 Director 1**X** M 2 □ F 55 December 1,1956 Maryland Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Md. Anne Arundel Glen Burnie 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 ms 23a or must be r Funeral 1120 Wynbrook Road 21060 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married XYes 2 No Maryland 21215-0036 be filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 X No Specify: White Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Mail Carrier U.S. Postal Service 12 years event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever ပ္ Henry Martin Clark Sr. Ruth A. Harbstreet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Debra A. Clark Wife 1120 Wynbrook Road, Glen Burnie, Md. 21060 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of May <sup>□</sup>9°, 2012 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Baltimore, Maryland Bayview Crematory 4 Donation 5 Other (Specify) permit. o Funoral Sen Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Card. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Serere disease or condition Medical resulting in death) Examiner Secure trally list over differen Examine if any, leading to immediate cause. Enter Underlying >3 mouths attending physician and after use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hospital or Attending Physician: The law has completely filled in by the funeral director, page 2 performe this certificate 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Yes 2 No ပ္ 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury 28b. Time of After t 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after death Funeral Director; 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I only one) 29c. License number P 26618 Name and address of person who completed cause of death (Item 23a) (Type, Print)
- Buijut Kumar, 9005. Calm Are, Balkimor, MD-21229

DHf/11 17 Flev 05 2011

State

Registrar

31. Date filed Wonth, Day, Year)

MAY 1 0 2012

32. Registrar's Signature

|                                     |  |  | Otate of Ivia   | •                                   | ertificate           | of Death   |                                 | g. No.                       |  |          |
|-------------------------------------|--|--|---|-------------------------------------|----------------------|--|---------------------------------|------------------------------|--|----------|
|                                     |  | 1. Decedent's Name (First, Middle, La  | st)   |                                     |                      |  | 2. Date of Deeth<br>Month       | 1                            | 3. Time of Death   |          |
|                                     | Physician  | Robert R. Chris  | ty  |                                     |                      |  | April 28                        | 3, 2012                      | 8:00 PM_   |          |
| }                                   | /Medical<br>Examiner   | 4e Fecility Neme (If not institution, giv  |   |                                     |                      | 4b. City, Town, or L                             | ocation of Deeth                | 4c. County of                | Deeth  |          |
| all the                             | <i>*</i>   | North Hampton No   | ursing & Re   | ehab Cent                           |                      | Frederic   |                                 | Freder                       |  |          |
|                                     | Funeral  | Social Security Number     6. S  |   | (In yrs. lest birthd                | Months   D           |  | (Month, Day,                    | Yeer)                        | Birthplace (State or Foreign<br>Country)   | n        |
|                                     | Director   | 220-14-3268  | M 2□ F  | 87 Yrs                              |                      |  | May 14,                         | 1924                         | Maryland   |          |
|                                     | pue *  | Usuel Residence of Decedent  10a. State 10b. County  |   | 10c. City, Town o                   | Location             |  |                                 |                              | 10d. Inside City Limits  | s        |
|                                     | f sho  | MD Frederi   | o.lz  | Frede                               |                      |  |                                 |                              | 1 ☐ Yes 2 ☐ No   | 2        |
| ,                                   | 138 138 138 138 138 138 138 138 138 138  | 10e. Street end Number   | CK  | rrede                               | 10f. Zip Co          | de   | 10                              | g. Citizen of Wh             | net Country?   | $\neg$   |
| 3                                   | inter death with the Mei<br>r items 23e or 28e-f s<br>inter must be notified<br>Funeral Director   | 4503 Araby Chur  | ch Road   |                                     |                      | 21704  |                                 | USA                          |  |          |
|                                     | ms 2:  | 11. Marital Status   | 12. Was Decedent B                                      | ever in U,S.                        | 3. Was Decedent      | of Hispanic Origin? (Sp<br>Cuben, Mexican, Puert | pecify Yes or No-               |                              | - American Indian,<br>White, etc.  |          |
| 020                                 | permit. Peges 1 and 2 should be liled within 72 hours effer death with the Meryland Depertment of Heath and Mentle Hygiene. Depertment of Heath and Mentle Hygiene. Important: If learn 27 is marked other than 'natural', or items 23e or 28e-f show any injury or other traumetic event, the Medical Examinar must be notified at once.  To Be Completed by Funeral Director                         | 1 ☐ Never Married 2 ☐ Married 3 💹 Widowed 4 ☐ Divorced   | Armed Forces?  1. Yes 2 □ N If Yes, Give Year or Dates: |                                     | 1 Tes, specify       |  | o riioan, oto.)                 |                              | white  |          |
| Ş                                   | 2 hou  | 15. Decedent's E   | ducation  | 16e. De                             | cedent's Usual O     | ccupetion<br>one during most of wor              |                                 | 16b. Kind of Bus             | iness/Industry unk   |          |
| 717                                 | ple  | (Specify only highest gra<br>Elementary/Secondary (0-12)   | College (1-4or 5  | Iii                                 | e. DO NOT use r      | etired)  | Amg                             |                              |  |          |
| 7                                   | or The Corr  | 12   | 4   | che                                 | emical e             |  |                                 |                              |  | $\dashv$ |
| פ                                   | should be filed within 72 hos<br>Momel Hygiene. I marked other than "natura<br>umetic event, the Medical i<br>To Be Completed  | 17. Fether's Name (First, Middle, Lest   |   |                                     |                      |  | ne (First, Middle, M            |                              | ,  |          |
| <u> </u>                            | Ment Ment To I   | Robert Henry C   | -   |                                     |                      |  | laire Ru                        |                              | tota Zin Cada)   |          |
|                                     | is m<br>raum   | 19a. Informent's Name/Relationship ( Barbara L. Berma  | • •   | 1                                   |                      | treet and Number or Ru<br>y Church Ro            |                                 |                              |  |          |
|                                     | 1 end<br>4eaith<br>3m 27<br>ther tr  | 20a. Method of Disposition   | ii, uaugiiter   | 20b. Place of D                     | sposition (Name      | of   |                                 |                              | ity or Town, State   |          |
| Baltimore,                          | Peges<br>nent of It<br>int: if ite<br>ary or of  | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 🕅 Donetion 5 ☐ Other (Specification of the control of the contr | <b>(y</b> )   | cemetery,                           | cremetory or othe    | r place)   |                                 |                              |  |          |
| Balt                                | permit. Depertrimports any inju  | 21. Signature o guneral Service Lic  | Wade ir   | ctor                                | State A              | natomy Boa                                       |                                 | Baltim                       | ore Street   |          |
|                                     | _  | 22a Part 1 Anter the disease of com  | trations that caused                                    | the death. Do not                   | Baltimo              | re, MD 212                                       |                                 | est,                         | Approximate  |          |
| 5                                   | Physician<br>/Medical  | 23a. Part1. Inter the disease, ir com shock, heart failure. List only Immediate Cause (Final   | ()  | 1                                   |                      |  |                                 |                              | Interval Between<br>Onset and Death  |          |
|                                     | Examiner   | disease or condition<br>resulting in death)  | e   | ement                               | 19                   |  |                                 |                              |  | -        |
| 1                                   | P P  |  |   | Due to (or as a cor                 | +                    | y dise   | CO.                             |                              | 1  |          |
|                                     | ansit  | Convention list conditions   | D   | Due to (or as e co                  | sequence of):        | 7 4 50.  | 1 30                            |                              |  |          |
| o,                                  | exec<br>an en<br>riel-tra  | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  |   |                                     | ,                    |  |                                 |                              |  |          |
| 68760,                              | icete be executed physician end s the buriel-transit edical Examiner   | Cause (Disease or injury that initiated events resulting in death) Last  | C   | Due to (or as e cor                 | sequence of):        |  |                                 |                              |  |          |
| 39 )                                | ng pt<br>s es ti   | issuming in south) East  |   |                                     |                      |  |                                 |                              |  |          |
| 9                                   | uth ce<br>ttendi<br>or use   |  | d   |                                     |                      |  |                                 |                              | 1  |          |
|                                     | the ell hed for /sic/  | Part II. Other significant conditions  | contributing to death bu                                | ut not resulting in th              | e underlying cau     | se given in Pert I.                              |                                 | × /                          | tribute to the cause of death  | - 1      |
| <u>.</u>                            | het th   |  |   |                                     |                      |  | 1 🗆 Y                           | es 2 <b>34</b> 0             | 3 ☐ Probably 4 ☐ Unknow  | wn       |
| Division of Vital Records, P.O. Box | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours elaster death.  To the Funeral Director: Attenthis certificate has been signed by the ettending physician and completely tilled in by the funeral director, page 2 should be deteched for use as the buriel-transit Medical Certification: To Be Completed by Physician/Medical Examin |  |   |                                     |                      |  | 24a. Was a perform              | n autopsy<br>med?            | 24b. Were autopsy findings<br>available prior to<br>completion of cause<br>of death? | 5        |
| ě                                   | hes<br>ge 2  |  |   |                                     |                      |  | 1 🗆 Y                           | es 2 No                      | 1 ☐ Yes 2 ☐ No   |          |
| ā                                   | n: The ficete or, pa   | 25. Was case referred to medical   |   |                                     |                      | 26. Place of De                                  | ath (Check only or              |                              |  |          |
| 5                                   | s certific<br>director   | examiner?  | Hospital: 1 ☐ Inpatie                                   | ent 2 ER/Outp                       | atient 3 DOA         | Other  | dome 5 Reside                   |                              | r (Specify)  |          |
| n of                                | Ing Physic<br>After this co<br>unerel dire<br>Ion: To  | 27. Manner of Death  1 Naturel 5 □ Pending   | 28a. Date of Inju<br>(Month, De                         | ry 28b. Tin                         | ne of 28c            | Injury et Work?                                  | 28d. Describe h                 |                              |  |          |
| ivisic                              | tal or Attending Pisselfer death.  al Director: After tied in by the funere Certification:   | 2 Accident investigation 3 Suicide 6 Could not to determined   | De Since of Init  | ury - At home, farm<br>c. (Specify) |                      |  | 28f. Location (S<br>City or Tow | treet and Numbe<br>n, State) | er or Rural Route Number,  |          |
|                                     | oftal o  | 200 Contilion Bot outstand   | hunialant Tatha hart                                    | of my knowledge                     | leath cooured of     | the time, date and place                         | a and due to the o              | ause(s) and mai              | nner as stated.  |          |
|                                     | n 24 hou<br>n 24 hou<br>he Funer<br>pletely fill<br>edical   | 29a. Certifier Certifying Pl<br>(Check only one) 2 Medical Exa   | miner: On the basis of<br>and menner ste                | examination and/                    | or investigation, in | my opinion, death occi                           | urred at the time, o            | late and place, a            | and due to the cause(s)  |          |
|                                     | within on the omple  | 29b. Signature end title of certifier  |   |                                     | 29c. L               | icense number                                    | 2                               | 29d. Date signed             | (Month, Pey, Year)   |          |
|                                     | - 5 - 0  | 1 James In   | rener 1   | MO                                  | $\mathbb{D}$         | 36421  |                                 | 05                           | 01/2012  |          |
|                                     |  | 30 Name end address of person who  | completed cause of d                                    | leath (Item 23e) (I                 | /pe, Print)          | #104 Fred  | prick /                         | NV 31                        | 701  |          |
|                                     | Cint   | 31. Dete filed (Month, Day, Year)  | 82. Registr   | or's Signature                      | ield nu              | IVI TIEU   | CTION 1                         | .0 01                        | 101  |          |
|                                     | State  | MAY 1 0 201  | 2 5.  | 1 1                                 | 0. 4.1               |  |                                 |                              |  |          |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  |                 | -         | For State State Registrar  | e of Maryland   |                               | artment of F<br><i>tificate of L</i>     |                                       | , ,                          |                                       | 12                  | 11  | . Ω Ι. Ε             |
|--|-----------------|-----------|--|---|-------------------------------|--|---------------------------------------|------------------------------|---------------------------------------|---------------------|---|----------------------|
|  |                 |           | Decedent's Name (First, Middle, Last)  |   | 061                           | imeate of L                              | Jean                                  | 2. Date of Deat              |                                       | 116                 | 3. Time o                                 | of Death             |
|  | sician<br>edica | 1         | Sarah H. Disharoon   |   |                               |  |                                       | April                        | 25 201                                | . 2 <sup>Year</sup> | 7:06                                      | 6 P M                |
| Exa  | mine            | r         | 4a. Facility Name (if not institution, give street and   |   | :                             |  | Location of Death                     | 1                            | 4c. County                            | of Death            | 0.0                                       |                      |
| Fune   | eral            |           | Wicomico Nursing 5. Social Security Number 6. Sex  | 7. Age (In yrs. las   | st birthday)                  | Salis<br>If Under 1 Year                 | If Under 24 Hrs.                      | 8. Date of Birth             | <u> </u>                              | 9. Birthp           | lace (State                               | or Foreign           |
| Direc  |                 |           | 172-22-0482 1 ☐ M 2 X  | 98  | Yrs.                          | Months Days                              | Hours Min.                            | Feb 3,                       | Ĭ914                                  | Mary                | Tand                                      |                      |
| land<br>show   |                 | בַּן      | 10a. State 10b. County   | 10c. City,  | Town or Loc                   | ation                                    |                                       |                              | · · · · · · · · · · · · · · · · · · · | 10                  | 0d. Inside C                              | City Limits          |
| Mary 28a-f   |                 | lice      | MD Wicomico  |   | Sali                          | sbury                                    |                                       |                              |                                       |                     | 1 🗆 Yes                                   | es 2 No              |
| vith the   | 100             | اع        | 10e. Street and Number 300 1emon Hill Lane   |   |                               | 10f. Zip Code                            | 21801                                 | 1                            | 0g. Citizen of W<br>USA               |                     | try?                                      | 1                    |
| leath v<br>items   |                 | - 1       | 11. Marital Status 12. Was I   | Decedent Ever in U.S.<br>d Forces?  | 13. W                         | /as Decedent of Hi                       | spanic Origin? (Sp                    | ecify Yes or No-             |                                       | - America           | an Indian,                                |                      |
| urs after c<br>ural", or a   |                 | 습         | 1 Never Married 2 Married 1 If Yes   | Yes 2 🗓 No  |                               | Yes, specify Cuba  ☐ Yes 2 🙀 No          | Specify:                              | Hican, etc.)                 |                                       | white, e            |   |                      |
| 2 hou  |                 | Completed | 15. Decedent's Education (Specify only highest grade comple  | eted)   | (Give k                       | ent's Usual Occupa<br>ind of work done o |                                       | king                         | 16b. Kind of Bus                      | siness Ind          | ustry                                     | unk                  |
| vithin jiene.  |                 |           | Elementary/Seconday (0-12) Colleg  | ge (1-4 or 5+)  |                               | NOT use retired)  kkeeper                |                                       |                              |                                       |                     |   |                      |
| filed vital Hyg  |                 | o pe      | 17. Father's Name (First, Middle, Last)  |   |                               | ALCOOPUL                                 | 18. Mother's Nam                      | ne (First, Middle, M         | laiden Surname)                       |                     |   |                      |
| I yid<br>buld be<br>d Men<br>marke   | '               | -         | Nathan James Anders  19a. Informant's Name/Relationship (Type, Print)  | ion   |                               |  |                                       | Powe11                       |                                       |                     |   |                      |
| , Mid<br>od 2 sho<br>satth an<br>n 27 is   |                 |           | Christine Disharoon/d  | laugher   | 19b. Mailing                  | g Address (Street a<br>Hazel Si          | ind Number or Rur<br>treet Sal        | al Route Number,<br>Lisbury, | City or Town, Sta  MD 218             |                     | ode)                                      |                      |
| Deficient of the Marylating Z.I.Z.13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Iniux or other trainmatic event, the Medical Examinar must be notified at |                 |           | 20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 1  4 ☑ Donation 5 ☐ Other (Specify)                       | rom State 20b. Pla  | ace of Dispos<br>metery, crem | ition (Name of<br>atory or other place   | e)                                    | Date                         | 20c. Location - 0                     | Dity or Tov         | vn, State                                 |                      |
| permit. Departr Import   | ouce.           |           | 21. Signature of F. nerry service Licenses   | Director  | St<br>Bo                      | Name and Addres<br>ate Anato             | s of Facility Omy Board               | l 655 W.                     | Baltimo                               | re S                | treet                                     |                      |
| Priysicia  | an/             |           | 23a. Part 1 Enter the disease, or complications the shock, or heart failure. List only one cause of Immediate Cause (Final | nat caused the death.<br>n each line.   | Do not enter                  | the mode of dying                        | g, such as cardiac                    | or respiratory arres         | st,                                   |                     | Approximat<br>Interval Bet<br>Onset and I | tween                |
| → Medio  | cal             |           | disease or condition resulting in death)  a  | to (or as a conseque  |                               | DCAT                                     |                                       |                              |                                       | -                   |   |                      |
| XGIIIII  |                 | 5         | Sequentially list conditions, if any, leading to immediate Due   | to (or as a conseque  | nce off:                      |  |                                       |                              |                                       | $\perp$             |   |                      |
| uted   | Fyaminer        |           | cause. Enter Underlying Gause (Disease or injury that initiated events  c  |   |                               |  |                                       |                              |                                       |                     |   |                      |
| ate be executed physician and the burial-transit   | Adical E        | 3         | resulting in death) Last Due   | to (or as a conseque  | nce of):                      |  |                                       |                              |                                       |                     |   |                      |
| ifficate<br>ng phys<br>as the  | 1 - 2           |           | F FEMALE:  |   |                               |  |                                       |                              |                                       |                     |   |                      |
| or Attending Physician: The law requires that the death certificate be executed and death certificate be executed birector: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transi   | Veician/M       |           | 23b. Was decedent pregnant 23c. If yes, in the past 12 months? 1   | outcome of pregnand<br>live Birth 2  Fetal or<br>Pregnant at time of dea<br>Inknown | death 3 🗌                     | Ectopic pregnancy<br>Other (specify)     | ′                                     |                              | 23d. Date<br>Mont                     |                     |   | Year                 |
| that the dealed by the a   | hy Phy          |           | Part II. Other significant conditions contributing   | to death but not result   | ting in the un                | derlying cause give                      | en in Part I.                         | 23e. Did tob                 | acco use contrib                      | ute to the          | cause of d                                | leath?               |
| v requires the been signer should be a   | 1               |           |  |   |                               |  |                                       | 1 □ Ye                       | s 2 🗆 No 3                            | Proba               | ably 4                                    | Unknown              |
| law re<br>has be<br>e 2 sho  | Completed       |           |  |   |                               |  |                                       | 24a. Was an<br>autopsy       | / pri                                 | or to com           | sy findings a                             | available<br>ause of |
| ician: The la<br>certificate ha  |                 |           | 25. Was case referred to medical   |   |                               | 00.51                                    | (5.1)                                 | perform<br>1 Yes 2           | led? de<br>□wo 1                      | eath?               | No  |                      |
| ysician:<br>is certific<br>director,   | To Be           | 1         | examiner?  | ☐ Inpatient 2 ☐ EF  | R/Outpatient                  | Other                                    | ce of Death (Checi                    | ome 5 Resider                | ace 6 🗆 Other                         | (Specify)           |   |                      |
| ling Ph<br>After th<br>funeral   |                 |           | 7. Manne f Death 28a. D  |   | 8b. Time of injury            | 28c. Injury<br>work?                     | at                                    | 28d. Describe hov            |                                       |                     |   |                      |
| Attend<br>r death<br>sctor: /  | Certificate     |           | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Pl  | ace of Injury - At home   | e, farm, stree                |  | res 2 ☐ No                            | 28f. Location (Stre          | eet and Number                        | or Rural F          | loute Numb                                | ner                  |
| ital or<br>irs afte<br>al Dire   | B               |           | 4 - Notflicide determined bu   | ilding, etc. (Specify)  | ,                             |  |                                       | City or Town,                |                                       | or murar m          | oute marrip                               | 61,                  |
| To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completed filled in by the funeral di  | Medical         |           | 29a. Certifier (Check only one)  1 Certifying Physician: To the 2 Medical Examiner: On the 3 Certifying Nurse Praction     | basis of examination a  | nd/or investic                | ation, in my opinior                     | <ul> <li>death occurred at</li> </ul> | the time date and            | place and due to                      | o the cause         | ale) and mar                              | nner stated.         |
| To t   |                 | 2         | 9b. Signature and title of certifier   |   |                               | 29c. License                             |                                       |                              | d. Date signed (                      |                     |   |                      |
|  |                 | 2         | io. Name and address of person who completed of  | AUSE of death (Itam Of  | 3a) /Time D                   | <u>D60</u>                               | 15/5                                  |                              | 7/26/                                 | 12                  |   |                      |
|  |                 |           | MILHIMMANAYAPPI  | 910   | EASTE                         | -PN SH                                   | THE PI                                | R, SAL                       | ISBUN,                                | XM                  | 02/2                                      | 804                  |
| S<br>Regi:   | State<br>strar  | 3         | 1. Date filed (Month, Day, Year) NAY 1 0 2012  | A 9/0<br>Registrar's Signatur   | fa                            | Ke                                       |                                       |                              |                                       |                     |   |                      |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 15 pm Year Physician/ Month Jerald Diesel 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death FRANKLIN SQUARE HOSPITal Rosedale BalTimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** OCT 14, 1963 Months Days Hours 214-64-3707 1 **X** M 2 □ F 48 Maryland **Director** Usual Residence of Decedent show or 28a-f shown notified at 10a. State 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes XXNo MD Baltimore Dundalk 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 1612 Searles Road 21222 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White Completed by 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Systems Connection 10 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Joseph Diesel June Cullison 19a. Informant's Name/Relationship (Type, Print) Robin Diesel/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) les 1612 Searles Road Dundalk, MD. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery : 05/11/12 Baltimore, MD 4 Denation 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave Balto MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ametastatic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Esquerdamy list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ted Cause (Disease or injury that initiated events resulting in death) Last for use as the burial-tran signed by the attending physician and or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? within 24 hours after death.

To the Funeral Director: After this certificate 2 🗌 No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Yes 2 No Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 🖆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 062 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, Robert 31. Date filed (Month, Day, Year) 32. Registra State MAY 1 0 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2ď12 7:26 P M May Charlotte Ann Davis Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring Social Security Number 7. Age (In vrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 578-42-8180 **Director** 1 □ M 2 🕅 F 78 July 21, 1933 Maryland Usual Residence of Deceden show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 🗌 Yes 2 🔀 No MD Montgomery Silver Spring 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 9103 Louis Avenue 20910 United States items 2 death al Hygiene. d other than "natural", or item: event, the Medical Examiner m 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic v traumatic William Clarance Doris Alma Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Davis Huggins / Daughter 3825 Old Baltimore Dr. Olney, MD 20832 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 5/10/2012 Woodbine, Maryland 21. Signature of Moneral Service Lie Going Home Cremation Service P.O. Box 784 MO1651 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Metastatic Encerhalogathy disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events southing in death). Examine Due to (or as a consequence of) Pneumonia Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical that the death certificate be P.O. Box 68760 attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 X No Pregnant at time of death Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autonsv 1 ☐ Yes 2 🔀 No 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Tyes 2 🔀 No ဂ္ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) I Director: After the funers Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) filled in hours a 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 24 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

(oV

29b. Signature and title of certifier

Nabila Khan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Rd. Silver Spring, MD 20910

D65305

29d. Date signed (Month, Day, Year)

May 9, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yea **Physician** Clo2S A M 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days **™** M 2 □ F 216-66-3494 59 December 25,1952 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 XNo Md. Baltimore Dundalk Director must be notified 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Apt. 410 21222 101 Center Place USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" any Injury or other traumatic event of the property of the prope 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify If Yes, Give Specify: White þ 3 ☐ Widowed 4 X Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Bus Driver Hoffman Bus Company 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tobias Detzel Gloria Lowes ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brad Detzel 29 Township Road, Dundalk, Md. 21222 Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 XCremation 3 Removal from State Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 21. Signature of Funeral Service Licensee 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Pag 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as consequence of) neumonic Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner Due to (or as a consequence of) use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IE FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy director, page 2 should be detached for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an performed? 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: 1 Natural (Month, Day 5 Pending investigation 1 🗌 Yes 2 🗌 No ☐ Accident the Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, determined

**Examiner** I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Box 68760, P.O. Division of Vital Records. filled in by 24 hours a

death with the Maryland

28a-f show

ö

23a

items

To the Vithin 2

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my acid 29a. Certifier cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

City or Town, State)

State Registrar 31. Date filed (Month, Day, Year,

4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ VAR 00 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ROSS HOSPIFAI UER SPRING MONTGOMERY 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) unk **Funeral** Days Hours (Month, Day, Year) 17-34-188 **Director** 1 M 2 - F 72 03,12 ,1937 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 □ No KENSINGTON MONTGOMERY 10e. Street and Number ŏ 10g. Citizen of What Country? pe Funeral 0895 5000 S MCCOMAS AVE U 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or ite Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed 3 Divorced 4 Divorced WHITE Year or Dates. UNK 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk f Health and Mental Hitem 27 is marked of 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOLY CROSS 1500 FOREST HOSPITAI GLEN RO S.S. MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ± 5 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Important: In any injury or once. 4 Donation 5 N Other (Specify) in state Signature of Fune al Service Licenses Ronald S. Made Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ PNEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ত Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury Q11 STAGE DEMENTIA inding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L. Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the at g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy Director: After this certificate 2 No 2  $\square$  No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \( \sum \) Yes 2 \( \sum \) No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury work?
1 Yes 2 No death. Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760 P.0. Records, Division of Vital the Hospital or Attending Funeral

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 POREST AHZINA KUMAR MB. SILVER CLEN RD SPRING MD 20910

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

243240

State Registrar (Check

only one

|                            |   |                            | For  | State of Maryland / Depart  | rtment of Health and I   |   | 0   | •   |
|----------------------------|---|----------------------------|--|---|--|---|---|---|
| _                          |   |                            | State Registrar  | Cer   | tificate of Death  | Reg.                                      | No. 201                                     | 2   4851  |
|                            | Physicia<br>Medic   |                            | 1. Decedent's Name (First, Middle, Last)  Mary K. Da   | ivis  |  | 2. Date of Death<br>Month<br>May          | Day Year 8 2012                             | 3. Time of Death 5:20 A. M                                |
| area.                      | Examin  |                            | 4a. Facility Name (if not institution, give stree  | et and number)  | 4b. City, Town, or Location of Death   | 1112                                      | 4c. County of Dear<br>Baltimo               | th<br>CCG   |
| m,,,,,,,,,,                |   |                            | Gilchrist Hospice  5. Social Security Number   6. Sex  | 7. Age (In yrs. last birthday)  | TOWSON  If Under 1 Year   If Under 24 Hrs.   | 8. Date of Birth                          |   |   |
|                            | Funeral<br>Director   |                            | 210 10 5144  | 1 2 XXF 88 Yrs.   | Months Days Hours Min.   | Month, Day, Ye.                           | ar) Co                                      | thplace (State or Foreign<br>untry)<br><b>t.</b> Maryland |
|                            | yland<br>-f show<br>ed at   | ctor                       | 10a. State 10b. County Maryland Baltimor   | 10c. City, Town or Loc  | ration Timon   |   |   | 10d. Inside City Limits                                   |
|                            | or 28a  | Dire                       | 10e Street and Number  |   | 10f. Zip Code  | 100                                       | . Ciţizen o <u>f</u> What Co                | 1 🗆 Yes 2 🖾 No  |
|                            | ar daeth with the Maryland<br>or Items 23a or 28a-f sho<br>Direr mat be polified at   | Funeral Director           | 12261 Roundwood F  |   | 21093  |   | nited Sta<br>of Ameri                       | ates  |
| 9036                       | 2 hours efter deeth with the Maryland<br>"natural", or Items 23a or 28a-f sho<br>dicel Examiner must be notified at   | þ                          |  | Armed Forces? If<br>1 ☐ Yes 2 ☑ No  | Vas Decedent of Hispanic Origin? (Sp<br>Yes, specify Cuban, Mexican, Puerto<br>Yes 2 X No Specify: | ecify Yes or No-<br>o Rican, etc.)        | 14. Race - Ame<br>Black, Whit<br>Specify: W |   |
| Maryland 21215-0036        | 72  | Completed                  | 15. Decedent's Educa<br>(Specify only highest grade of<br>Elementary/Secondary (0-12)  | completed) (Give k<br>College (1-4 or 5+)   | ent's Usual Occupation<br>ind of work done during most of wor<br>O NOT use retired)<br>emaker      | king 16i                                  | o. Kind of Business.                        | •   |
| yland ?                    | a 1 and 2 should be filed within of Health end Mental Hygiena. of Health end Mental Hygiena. If Item 27 is marked other than rother traumatic event, the Merothar traumatic event, the Merothar traumatic event, the Merothar   | To Be                      | 17. Father's Name (First, Middle, Last) Peter Kuehn  |   | 18. Mother's Nar<br>Caro   | ne (First, Middle, Maid<br>line Frede     | den Suroame)<br>ETICK                       |   |
|                            | nd 2 shou<br>ealth end<br>m 27 Is m   |                            | 19a. Informant's Name/Relationship (Type, Paula Davis Setters  | erint) daughter 19b. Mailin 13232   | g Address (Street and Number or Ru<br>2 Jarrettsville P  | ral Route Number, Cit<br>ike Phoen        | y or Town, State, Zi<br>Nix, Mary.          | Land 21131  |
| Baltimore,                 | parmit. Pege 1 a Dapertment of H Important: If Itel any Injury or ott   |                            | 20a. Method of Disposition 1 ☐ Burial 25 Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)  | 20b. Place of Disposinoval from State  20b. Place of Disposinoval From State  EVANS FI Chapel-                                    | atory or other place) May  | 10,                                       | c. Location - City or<br>Corest Hi          | Town, State   |
| Balt                       | parmit. Dapert Import any inj   |                            | 21. Signature of Juneral Service Licensee  |   | Name and Address of Escility ves<br>eaceful Alternatives<br>2325 York Road Tim                     | Funeral and                               | Cremation and 21093                         | Center, P.A.  |
| E                          | Priysician/   |                            | 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one commediate Cause (Final disease or condition                            | tions that caused the death. Do not ente<br>ause on each line.  | r the mode of dying, such as cardiac   | or respiratory arrest,                    |   | Approximate<br>Interval Between<br>Onset and Death        |
|                            | Medical<br>Examiner   | e.                         | resulting in death)  Sequentially list conditions,  b  |   | olitis and f   | injem                                     | `~  | weeks   |
|                            | i be axecuted<br>siclan end<br>a burial-trensit   | cal Examiner               | Sequentially list conditions, if any, leading to immediate cause. Einet Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of):  Conviluation of the Due to (or as a consequence of):  | sugary for   | bovel obs                                 | more  | bureles   |
| 90                         | eta be<br>chysic<br>tha b   |                            | d  |   |  |   |   |   |
| Box 6876                   | To the Hospital or Attending Physician: Tha lew requires thet the deeth certificeta i within 24 hours after death. To the Funeral Director: Aftar this certificate hes baen signed by tha attanding phys completely filled in by the funeral director, page 2 should be datached for usa as tha | Completed by Physician/Med | in the past 12 months?   |   | Ectopic pregnancy<br>Other (specify)   |   | 23d. Date of de<br>Month                    | livery<br>Day Year  |
| s, P.O.                    | Attending Physician: Tha lew requires thet the deeth redeath. sctor: Affar this certificate hes baen signed by tha atta by the funeral director, page 2 should be datached for by the funeral director, page 2 should be datached for the funeral director.                                     | d by Ph                    | Part II. Other significant conditions contrib  | outing to death but not resulting in the u  | nderlying cause given in Part I.   |   |   | o the cause of death?                                     |
| Division of Vital Records, | na lew requ<br>e hes baer<br>age 2 shou   | omplete                    |  |   |  | 24a. Was an<br>autopsy<br>performe        | prior to death?                             | topsy findings available completion of cause of           |
| E H                        | an: The   |                            | 25. Was case referred to medical   |   | 26. Place of Death (Che  | 1 ☐ Yes 2 ☑<br>ck only one)               | MNo 1 ☐ Yes                                 | s 2 🗆 No  |
| VIII                       | nysich<br>is cer<br>direc   | 10 B                       | examiner? 1  Yes 2 No  | oital: 1  Inpatient 2 ER/Outpatien  | Other  | ome 5 🗆 Residence                         | e 6 X Other (Spec                           | IN HUSPICE  |
| n of                       | nding Ph<br>tth.<br>: Aftar th<br>e funeral   | cate:                      | 27. Manner of with  1 Natural 5 Pending 2 Accident Investigation   | 28a. Date of injury<br>(Month, Day, Year) 28b. Time of<br>injury  | 28c. Injury at work?  M 1 ☐ Yes 2 ☐ No   | 28d. Describe how it                      | -   |   |
| Divisio                    | tal or Atters after dester des dester des  | Medical Certificate:       | 3 Suicida 6 Could not be   | 28e. Place of Injury - At home, farm, stre building, etc. (Specify)   | et, factory, office  | 28f. Location (Street<br>City or Town, St |   | ral Route Number,   |
|                            | n 24 hour<br>n 24 hour<br>ne Funera<br>pletely fill   | Medica                     | (Check 2 Li Medical Examiner:  | n: To the best of my knowledge, death o<br>On the basis of examination and/or investi<br>actitioner: To the best of my knowledge, | gation, in my opinion, death occurred :  | at the time, date and pl                  | ace, and due to the                         | cause(s) and manner stated.                               |
|                            | To with   |                            | 29b. Signature and title of certifier  | ~~n   | 29c. License number  |   | Date signed (Mont)                          |   |
| له                         |   |                            | 30. Name and address of person who comp  | eleted cause of death (Item 23a) (Type, Pr  | 701 N (Cha   | nle St                                    | DC WST                                      | N MM  |
|                            | Stat<br>Registra  |                            | 31. Date filed (Month, Day, Year) NAY 1 0 2012   | 3. Registrar's Signature  | No.  | .,- , , , ,                               | 1- 20                                       | /   |

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND PI LINE B, 25,27,28A-F, PER ME G928 6/28/12 TRT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 May Dembeck 2:59a Eleanor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Assisted Living Well Millersville Anne Arundel Co. 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Director 215-03-5701 1 M 2 X F 98 Nov29,1913 Maryland 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Pasadena Md. Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be Funeral 461 New York Avenue 21122 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: 3 ₩ Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10th Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Eva Sarpolis Joseph Mc Shane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code P.O. Box 72369 Baltimore, Maryland 21237 Elaine A. Weber /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State  $May^{\text{Date}}$ 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Bayview Crematory 10,2012 Baltimore, Maryland M00933 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee Nort 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death MYOCARDIAL Physician/ INFARCTION disease or condition Medical resulting in death) **Examiner** HIP FRACTURE WITH COMPLICATIONS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death ed by the a 1 Yes 2 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has to page 2 s autopsy performed 2 No Yes 2 X N 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Assisted Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\mathbb{X}\) Other (Specify) 1 X Yes ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Manner of Death 28a. Date of injury (Month, Day, Year) Medical Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After i Natoral
Accident injury 5 Pending work? 1 ☐ Yes 2 ☐ XNo Investigation 2/9/2012 **UNKNOWN** M SUBJECT FELL 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 265 PASADENA ROAD 4 Homicide determined ASSISTED LIVING FACILITY MILLERSVILLE, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)44315 5-8-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

280/ Fox Fee. Ave., Sa Itu. 2/224 Dr. Vincenzo Grippo, M. D 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Llwell Sar 5:25 AM Ma 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Montgomery 7103 Fulton Street Chevy Chase Social Security Number . Age (In yrs. last birthday) If Under If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Hours (Month, Day, Year) Director 201-32-8367 1 □ M 2 🔀 F Feb 12, 1941 Canada Usual Residence of Decedent 28a-f show 10b. County 10c, City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 XNo MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 7103 Fulton Street 20815 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 XMarried Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: Completed 3 Widowed 4 Divorced Year or Dates. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Administrative Assistant Peace Corps Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Department of Health and Ment: Important: If item 27 is marked any injury or any injur Wimburn Black Mildred Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Elwell / Husband 7103 Fulton St. Chevy Chase, MD 20815 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 🏿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 5/11/2012 Woodbine, Maryland 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 note MO1251 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Jears Cancer Metastatic Breast disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause Office on injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day Year q Unknown P.O. I ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performs After this certificate 2 **X**No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 1 Nursing Home | 5 \( \text{Residence} \) Residence | 6 \( \text{Other} \) Other (Specify) 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗌 No Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carrie Tilley 2150 Pennsylvania ave NW Washington DC 20037

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Physician/ Day :00 PM 10R Medical 4a. Facility Name (if not institution, give street and number 4b. City Town, or Location of Death 4c. County of Death Examiner ortsk Koa a Da Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** If Under 1 If Under 24 Hrs Months Director 1 M 2 D 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland at 10d. Inside City Limits Completed by Funeral Director must be notified 28a-f 1 Yes 2 No 10e. Street and Number 5 10g. Citizen of What Country? 23a U.SA 21222 an "natural", or items Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: WKIte 3 ₩idowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Home OWN tomena Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 21222 EIdINGE or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) OWINGS MILLS 22. Name and Address of Facility Astron Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each im. such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final Onset and Death Phinician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a sequence of) Cause (Disease of injury that initiated events attending physician and for use as the buriat-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death Unknown been signed by the a should be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaceo use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy 2 No ☐ Yes Yes the Hospital or Attending Physician: <sup>1</sup> thin 24 hours after death. Be 25. Was case referred to redical 26. Place of Death (Check only one) examiner? Hospital 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? Natural injury 5 Pending 2 Accident Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner, to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date eigi ad (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who

31. Date filed (Month, Day,

Hola

eted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month 2:40 PM C. Flemin eatrice) May 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NA Baltimore of Baltimore Sinai Hospital Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday 8. Date of Birth **Funeral** Min Hours Director 1 🗆 M 2 🔀 F 01101 1960 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at **Funeral Director** Baltimore Pikes ville 1 Yes 2 No 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? 714 Kahn 23a USA 21208 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ral", or iten Examiner Black, White, etc. 1 Never Married 2 A Married Completed by 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black "natural" 3 Divorced Specify: e 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, the Medical I Beatrice 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health Director Mental 12th grade 5+ years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Colbert Delares eroy Johnson Fleming 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code) 7907 Brookford Circle, Apt. L E. Jr. (Uncle) PIKESVILLE MD 2120E )ohnsen Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Dulaney Valley 05 15 2012 Timonium, MD Signature of Funeral Service Licenses 22. Name and Address of Facility vaughn C. Greene Funeral Services laugho. Road Pandalistown MD 21/33 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ Multifocal stroke 16 days disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? page 2 should be detached for Month Year Pregnant at time of death 9 Unknown 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Metastatic ovarian cancer 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy perform death? \_ Yes or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Vother (Specify) Hospice 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital within 24 hours To the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 06-2011

State Registrar 29a. Certifier (Check

3

Celi

YUKli Elliott, MD. sinai

M.D.

29b. Signature and title of certifier

Certifying Nurse Practitioner: To the best of my knowle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital of Baltimore

uned at the tin

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

May 8, 2012

2401 W. Bervedere Avenue Bartimore MD 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                            |   |              | For<br>State<br>Registrar                   | amend  | #13fatĕ⊕¥N                                       | fatylar       |                               | HMen¥o<br>tificate o              |                            | and M           |                                | giene<br>Reg. No. | 2012                      | )         | 11.855                                    |
|----------------------------|---|--------------|---|--|--|---------------|-------------------------------|-----------------------------------|----------------------------|-----------------|--------------------------------|-------------------|---------------------------|-----------|---|
|                            | Physicia  | ın/          | 1. Decedent's Name                          | e (First, Middle, La:  |  | )             |                               |                                   |                            |                 | 2. Date of De                  | ath               | - A Year                  | 3.        | Time of Death                             |
| ii.                        | Medic   | al           | 4a. Facility Name (if                       |  | Fe'in  | 19/1          | 255                           | 41. Oit. T                        |                            | - f D-+Ab       | May                            | <del>`</del>      | 2012                      | - /       | 1000 PM                                   |
|                            | Examir  | er           | 130 SLAD                                    | , 0  | ŕ  |               |                               | BALT                              | n, or Location of<br>EMORE | of Death        |                                |                   | County of Deat<br>BALTIMO |           |   |
|                            | Funeral   |              | <ol><li>Social Security Nu</li></ol>        | umber 6. S   | ex 7. Ag   | ge (In yrs. I | ast birthday)                 | If Under 1 Ye Months Dar          |                            | 24 Hrs.<br>Min. | 8. Date of Bir<br>(Month, Da   | th<br>v. Year)    |                           | thplace   | (State or Foreign                         |
|                            | Director  |              | 215-03-2<br>Usual Residence o               |  | □ M 2 🛛 F  |               | 96 Yrs.                       |                                   |                            |                 | 06/01                          |                   |                           |           | MD  |
|                            | /land<br>f show<br>ed at  | itor         | 10a. State                                  | 10b. County  |  | 10c. Cit      | y, Town or Loc                | ation                             |                            |                 |                                | •                 |                           | 10d. lr   | nside City Limits                         |
|                            | r 28a-<br>notifie   | Director     | MD<br>10e. Street and Num                   | BALTIM   | IORE   | BA            | LTIMOR                        |                                   |                            |                 |                                |                   |                           |           | 1 ☐ Yes 2 🕅 No                            |
|                            | should be filed within 72 hours after death with the Maryland<br>and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 2ae or 28a-f sho raumatic event, the Medical Examiner must be notified at   | Funeral      | 130 SLAD                                    |  | <i>.</i> #505                                    |               |                               | 10f. Zip Cod<br>2120              |                            |                 |                                | 10g. Citiz        | zen of What Co            |           | USA                                       |
|                            | items<br>items  |              | 11. Marital Status                          |  | 12. Was Decedent                                 | Ever in U.S   | S. 13. W                      | as Decedent o                     | f Hispanic Ori             | gin? (Spec      | cify Yes or No-                | 1                 | 4. Race - Ame             | rican Inc |   |
| 336                        | al", or   | d by         | 1 Never Marrie 3 X Widowed 4                |  | Armed Forces?  1 ☐ Yes 2 🛭  If Yes, Give         | No            |                               | ☐ Yes 2 🕅                         |                            | , , , , ,       | 110011, 010./                  | 8                 | Black, White<br>Specify:  |           |   |
| 2-0                        | hours<br>natur<br>dical E   | Completed    |   | 15. Decedent's E   |  |               | 16a. Deced                    | ent's Usual Occ                   | cupation                   |                 |                                | 16b. Kir          | WH.                       |           | у   |
| 121                        | thin 72<br>ne.<br>than "  | mo:          | Elementary/Secon                            |  | College (1-4 or                                  | 5+)           | life. DC                      | ind of work dor<br>NOT use retire | ed)                        |                 | ng                             |                   | OS/NI A CI                |           |   |
| d 2                        | ed wit<br>Hygie<br>other<br>ent, th   | Be C         | 12<br>17. Father's Name (F                  | First, Middle, Last)   |  |               | EXI                           | ECUTIVE                           |                            |                 | (First, Middle,                | Maiden            | SYNAG                     | UGUI      | <u> </u>                                  |
| /lan                       | d be fil<br>Aental<br>arked<br>tic ev   | 욘            | LOUIS                                       |  |  |               | WOLMAN                        |                                   |                            | RAH             | (r nat, whate,                 | waden o           |                           | DBEI      | RG  |
| Maryland 21215-0036        | shouli<br>and N<br>is ma  |              | 19a. Informant's Na                         |  |  |               | 1 44.                         | ,                                 |                            |                 |                                |                   | Town, State, Zip          |           |   |
|                            | and 2<br>Health<br>tem 27   |              | EDWARD F<br>20a. Method of Disp             |  | / SON  | 20h E         | 120                           |                                   | ER DRI                     |                 | EST HA                         |                   | RD, CT                    |           |   |
| Baltimore,                 | permit. Page 1 and 2 should be filed within 72 hour<br>popartment of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natuu<br>any injury or other traumatic event, the Medical<br>once.   |              | 1 X Burial 2                                |  | Removal from State                               | •   §         | RLINGT                        | on CEME                           | TERY                       |                 | 9/2012                         |                   | ALTIMOF                   |           |   |
| aalti                      | permit. I<br>Departra<br>Importa<br>any inju<br>once.   | 1            | 21. Signature Fun                           |  | ·  |               | CHIZUK<br>22.                 |                                   |                            |                 |                                |                   | BROS.,                    |           |   |
|                            | <u></u> □    □    □    □    □    □    □   |              | 222 523 5 5244                              | 09   |  |               |                               | 8900 R                            | EISTERS                    | STOWN           | ROAD,                          | PIKE              | ESVILLÉ                   | , MD      | 21208                                     |
|                            | hysician/   |              | shock, or heart<br>Immediate Cause (F       | t falilure. List only o                                      | plications that cause<br>one cause on each lin   | e. /          |                               |                                   | lying, such as             | cardiac or      | respiratory an                 | rest,             |                           | Inter     | roximate<br>rval Between<br>set and Death |
| ( )                        | Medical   |              | disease or condition resulting in death)    |  | a. Due to (or as                                 | a onsequ      | y Cl u                        | 19                                |                            |                 |                                |                   |                           |           |   |
|                            | Examiner  | <u>.</u>     | Sequentially list con                       | nditions,  | b. —   |               |                               |                                   |                            |                 |                                |                   |                           |           |   |
| 3                          | ed<br>nsit  | Examiner     | if any, leading to importance. Enter Underl | lying  | Due to (or as                                    | a consequ     | uence of):                    |                                   |                            |                 |                                |                   |                           |           |   |
|                            | sate be executed<br>physician and<br>the burial-transit   | Exa          | that initiated events resulting in death) L |  | c. Due to (or as                                 | a consequ     | ience of):                    |                                   |                            |                 |                                |                   |                           |           |   |
| 09.                        | ate be<br>physicia<br>the bu  | edical       |   | •  | d  |               |                               |                                   |                            |                 |                                |                   |                           |           |   |
| 687                        | ne death certifica<br>the attending pi<br>ched for use as t   | /Me          | IF FEMALE:<br>23b. Was decedent p           | oregnant   | 23c. If yes, outcome                             | of pregna     | ncy                           |                                   |                            |                 |                                |                   | 0.1.0                     |           |   |
| Box 68                     | eath c<br>e atten<br>d for u  | icial        | in the past 12 m                            | nonths?  | 1 Live Birth<br>4 Pregnant a                     | 2 Feta        | l death 3 🗌                   | Ectopic pregna<br>Other (specify) |                            |                 |                                | 2                 | 3d. Date of del<br>Month  | Day       | Year                                      |
| P.O. E                     | requires that the des<br>been signed by the s<br>should be detached   | Physician/M  | g Unknown                                   |  | 9 Unknown ontributing to death t                 |               |                               | ale 1.2                           |                            |                 |                                |                   |                           |           |   |
| G. 3                       | signed<br>d be d  | <b>5</b>     | rait ii. Other signim                       | cant conditions of   | ontributing to death t                           | out not res   | uiting in the un              | derlying cause                    | given in Part i            |                 |                                |                   | e contribute to           |           | use of death?                             |
| ord                        | v requi   | Completed    |   |  |  |               |                               |                                   |                            |                 | 24a. Was a                     |                   | •                         |           | ndings available                          |
| Rec                        | The lay   | Juo.         |   |  |  |               |                               |                                   |                            |                 | autop<br>perfor<br>1  Yes      | rmed?             | prior to death? 1 ☐ Yes   |           | ion of cause of                           |
| tal                        | ysician; The la<br>is certificate ha<br>director, page  | Be           | 25. Was case referred examiner?             |  | Hospital:  |               |                               |                                   | Place of Deat              |                 | only one)                      |                   |                           |           |   |
| of Vi                      | Physic<br>rthis c<br>eral dir   | 5: To        | 1 ☐ Yes 2 ₩<br>27. Manner of Death          | NO   | 1 Inpat  |               | ER/Outpatient<br>28b. Time of | 3 □ DOA 28c. In                   | iun, at                    | rsing Hom       | ne 5 Resid                     | lence 6           | Other (Speci              | fy)       |   |
| on o                       | ath.<br>r: Afte   | icate        | 1 Natural<br>2 Accident                     | 5 Pending Investigation                                      | (Month, Da                                       |               | injury                        | W                                 | ork?                       | - 1             | od. Describe II                | Ow anjury (       | occurred                  |           |   |
| Division of Vital Records, | or Affer<br>frer de<br>irecto<br>in by ti   | Certificate: | 3 ☐ Suicide<br>4 ☐ Homicide                 | 6 Could not be determined                                    | e 28e. Place of Inj<br>building, et              |               |                               | et, factory, offic                | е                          | 2               | 8f. Location (S<br>City or Tow |                   | Number or Rur             | al Route  | e Number,                                 |
| Ö                          | spiral ours a neral D   |              | 29a. Certifier 1                            | Certifying Phys  | sician: To the best of                           | my knowl      | edge death or                 | curred at the t                   | ime date and               | place and       | due to the co                  | use(e) and        | manner as st              | ated.     |   |
| , and a                    | To the hospital or Attending Priysician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Med          | (Check 2 l<br>only one) 3 [                 | <ul> <li>Medical Exami</li> <li>□ Certifying Nurs</li> </ul> | ner: On the basis of e<br>se Practitioner: To th | examination   | and/or investig               | ation, in my on                   | inion, death oc            | curred at t     | he time, date a                | nd place a        | and due to the o          | ause(s)   | and manner stated.                        |
| Ė                          | Nith Voith Control  |              | 29b. Signature and ti                       | tle of certifier   | Na   | 7             | mo                            | 29c. Lice                         | nse number                 |                 |                                | 29d. Date         | signed (Month             | , Day, Y  | 'ear)                                     |
|                            |   | -            | 30. Name and address                        | ss of person who   | completed cause of d                             | leath /Itam   | 23a) /Tunn 13-                | D/                                | 781                        | 2               |                                | May               | 1,2                       | 01.       | 2   |
| 10                         |   |              | Mous  | BCB  | 6938 A   | mas           | han                           | Blub                              | al                         | en              | BURN                           | 110               | 2/0                       | 6         |   |
|                            | Stat<br>Registra  | _            | 31. Date filed (Month,                      | Day, Year)   | 2 . Registr                                      | ar's Signa    | re far                        | مري                               |                            |                 |                                |                   |                           |           |   |
| DHMI                       | H 17 Rev 06-2   |              | 1115  | 1, = 0 = 0   | - John   | - 10          | -CJ                           |                                   |                            |                 |                                |                   |                           |           |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month AM arry George CIE 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center Birthplace (State or Foreign Country) If Under 24 Hrs 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** Days (Month, Day, Year) 180-38-3539 Director 1 X M 2 □ F 65 Feb 28, 1947 Nebraska Usual Residence of Dece 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗆 Yes 2 🔀 No Grasonville Maryland Queen Annes 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21638 USA 320 Timber Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 \( \square\) No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1967 Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify. Specify 3 Widowed 4 Divorced 1969 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self-Employed Courier Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mabel Huber Charles George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 320 Timber Lane Grasonville, Maryland 21638 Barbara Bennett, Friend 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 05/08/12 Baltimore, Maryland Metro Crematory Inc. 4 Donation 5 Other (Specify) Signature of Funeral Service License Thomas Gregor <sup>2</sup>Cremation 55ctety Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician -astrointestina disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a onsequence of) to immediate Exami the burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death been signed by the a should be detached f Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an after death.

Director: After this certificate has autopsy performed? Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident
Suicide 2 🗌 No 1 Yes Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Secrifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Dav. Year 29b, Signature and title 29c. License number

State Registrar

9

2001 Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician Karen Ann Guerrasio 2012 1:00 p M May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Catonsville Commons Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 56 216-68-5825 Oct 20 MD Director 1955 Usual Residence of Decedent filed within 72 hours after death with the Marylanc 10d. Inside City Limits 10a. State 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f show r traumatic event, the Modical Examinar mant to notified at 10b. County MD 1 XYes 2 □ No Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21229 USA 660 Charraway Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 X Never Married 2 ☐ Married Maryland 21215-0036 Specify: white 1 □ Yes 2 □ No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Police administrative assistant 12 should be filed with and Mental Hygier 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maurice M. Guerrasio Betty J. Hollenshade ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra Timothy Guerrasio (brother) 2430 Sandymount Rd, Finksburg, MD 21048 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State All County Cremation 5-11-12 Sykesville, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, MD

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death **Physician** Tastati months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of) If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical esn IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 Other (specify) signed by the a Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 □Yes 2 ♠No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes /2 **W**No this Medical Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 atural n 24 hours after death.

e Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Clty or Town, State) determined 4 ☐ Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24

State Registrar

29b. Signature and title of certifie

enniter

31. Date filed (Month, Day,

Registrar's Signat

of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

viation Blvd Glen Burnie Mi)

amend #31 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14859 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 8:00 **Physician** 2012 uan Jarcia /Medical 4c. County ol Death 4b. City, Town, or Logation of Death 4a. Facility Name (If not institution, give street and number) Examiner Maryland HACE'S If Under 24 Hrs. 8. Nashing Vine (0100 (State or Foreign 9. Birthplace Age (In yrs. last)b. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Min. Months unk 1 M 2□ F 5:5 269 Director Usual Residence of Decede 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a, State 10b. County or 28a-f show Examiner must be notified at 1 Yes 2 No Washingta MD Director tacestown 10g. Citizen of What Country? 10f. Zip Code unk 10e. Street and Number KURO (bun Funerai deeth 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian unk Black, White, etc. fited within 72 hours after 1 □ Never Married 2 □ Married ò 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify Vas Giva 2 mexican hispanic 3 ☐ Widowed 4 ☐ Divorced Year or Dates "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk unk 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 to Department of Health ar Important: If item 27 is any injury or other trauone. MDMCI 18601 Roxbury Road Hagerstown. 2174€ 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5፟ Other (Specify) in state nature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board Baltimore,MD 21201 Ronald S 655 W. Street Wac Baltimore Baltimore, MD 20 Approximate Interval Between Onset and Deat Enter the disease, or complications that or heart failure. List only one caus on ea Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Causs (Final disease or condition resulting in death) UlMorary 110114 **Physician** /Medical Due to (or as a conseque e of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physicien Physician/Medicai for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ Division of Vital Records, pe 2 No 3 Probably 4 Unknown 1 Yes page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has 2 No 1 ☐ Yes Physicien: 26. Place of Death (Check only one F1357 funeral director. 25. Was case referred to medical examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death After or Attending 1 Natural 1 Yes 2 No death. investigation 2 Accident filled in by the hours after deat unerel Diractor: 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cery D73397 30. Name and add completed cause of death (Item 23a) (Type, Print) 31. Date filed (M State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|   |                | Redistrar  | Certificate of         |   |                   | Re   | g. No. 2                             | 012 118   |
|---|----------------|--|------------------------|---|-------------------|--|--------------------------------------|---|
| Physici<br>cal Exam   |                | 1. Oecedent's Name (First, Middle,Last)  Kenneth Wayne Harris  |                        |   |                   | <ol> <li>Date of Death<br/>Month<br/>May 4, 201</li> </ol> | Day Year                             | 3. Time of Death * 0005 hrs                         |
|   |                | 4a. Facility Name (if not institution, give street and number)   | 41                     | b. City, Town, or Lo                        | ocation of Oeath  | Way 4, 201   | 4c. County of De                     |   |
| Funeral   | ۲              | 19 2nd Street  5. Social Security Number 6. Sex 7. Age (In y   | rs. last birthday)     | Lothian                                     | If Under 24Hrs.   | 8 Date of Birth  | Anne Arund                           |   |
| Director  |                | 216-70-7941 1M 2F  | 54 Yrs.                | Months Days                                 | Hours Min.        |  | For                                  | eign DistrictOf<br>Country) Columbia                |
| any .   |                |  | City, Town or Location | on  |                   |  |                                      | 10d. Inside City Limits                             |
| and show  | 5              | Maryland Anne Arundel  | Lot                    | hian  |                   |  |                                      | 1 Yes 2 No  |
| r 28a-  | Director       | 10e. Street and Number   |                        | 10f. Zip Code                               |                   | 10   | g. Citizen of What C                 | ountry?   |
| be filed within 72 hours after death with the Maryland natal Hygiene.  rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once. |                | 19 2nd Street  11. Marital Status   12. Was Decedent Ever i  | n II S I 13 Was        | 2071:<br>Decedent of Hispa                  |                   | ocify Ves or No-   | USA                                  | nerican Indian, Black,                              |
| r items   | Funeral        | 1 Never Married 2 Married Armed Forces? 1 Yes 2 N  | If Ye                  | s, specify Cuban, N                         | Mexican, Puerto F | Rican, etc.)   | White, etc                           |   |
| after c   | by F           | 3 Widowed 4 Oivorced If Yes, Give Year or Dates:   | 1 .                    | Yes 2 X No                                  |                   |  | Specify: Wh                          | ite   |
| hours<br>natur<br>Exam  |                | 15. Decedent's Education (Specify only highest grade completed<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |                        | s Usual Occupation<br>st of working life. D |                   |  | 16b. Kind of Busines                 | ss/Industry   |
| d 2 should be filed within 72 lth and Mental Hygiene.  n 27 is marked other than and the Medical  | Completed      | 10   | Truck                  | Driver                                      |                   | !  | Trucki                               | ng  |
| ld be filed within 72 hours after dental Hygiene.  narked other than "natural", event, the Medical Examiner   |                | 17. Father's Name (First, Middle, Last)  |                        | 18  | .Mother's Name (  | First, Middle, M   |                                      |   |
| uld be fil<br>Mental I<br>marked<br>e event,  | Be             | Leroy Gilbert Collins  19a. Informant's Name/Relationship (Type, Print)  | AOL Maritim            | Address (0)                                 |                   |  | richetti                             |   |
|   | 욘              | Patricia Murphy, Sister  |                        | •   |                   |  | per, City or Town, Sta<br>Land 20711 |   |
| E E E   |                | 20a. Method of Disposition   | Ob. Place of Dispositi | ion (Name of ceme                           |                   |  | 20c. Location - City                 |   |
| permit. Pages 1 a Department of He Important: If it injury or other t   |                | 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:  | letro Crem             | -   | 05/0              | 8/12   | Baltimor                             | e, Maryland   |
| epartm<br>nports<br>jury o  |                | 21. Signature of Funeral Service Lonsee Thomas Gree  | 22. Na                 | me and Address of<br>mation So<br>Frederic  | Facility          | of Maryl   | and Inc                              |   |
| nysician  |                | 23a. Part I. Enter the disease, or complications that caused the de  | 299                    | Frederic                                    | ck Road           | Baltin   | iore; MD 2                           | 21228<br>Approximate Interval                       |
| xaminer   | Examiner       | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Complication  Due to (or as a consequence of the condition of the condi |                        |   | Death             |  |                                      |   |
| e be execut<br>ysician and<br>burial - tra  | ledical        | x UNPENDED x AMENDED 23a,pt  | .II,27,28              | a-f,per                                     | ne,g930           | 8-27-12  | Sm                                   |   |
| certificate<br>nding phy<br>use as the  | 121            | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of p 1 Live birth 4 Pregnant at time of 9   | cy                     | 23d. Date of delive<br>Month                | Day Year          |  |                                      |   |
| ires that th<br>signed by<br>be detach  | ð              | Part II. Other significant conditions contributing to death but not the conditions and the conditions contributing to death but not not contributing to death but not contribute to contribute the contribution of contributing to death but not contribute the contribution of contributing to death but not contribute the contribution of contrib | •                      |   |                   |  |                                      | to the cause of death?                              |
| The law requires that the death cate has been signed by the atter page 2 should be detached for a   | Completed      | the liver  | .di Diseas             | e, cilin                                    | <u> </u>          | 24a. Was ar  | 24b. Were                            | autopsy findings available o completion of cause of |
| eian: The la<br>certificate h<br>ector, page  | Som            |  |                        |   |                   | perform<br>1 ✓ Yes 2                                       | ned? death?<br>No 1 ✓                |   |
| ysician: The l<br>his certificate b<br>director, page   | BB             | 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2   | ER/Outpatient          | low   | Death (Check or   |  | tesidence 6 🗸 Oth                    | nor: Scano  |
| ding Physi<br><br>After this<br>funeral dir   | ٠ <u>:</u>     | 27. Manner of Death 28a. Date of Injury  | 28b. Time of Inju      | 0 BOX                                       | T I Italiania     |  | ow injury occurred                   | let. Scene  |
| tendin<br>eath.<br>or: A<br>the fur   | ation          | 1 Natural 5 Pending (Month, Day, Year) 2 X Accident Investigation  | unknown                | 1 Yes                                       | 2 No              | subject  | fell                                 |   |
| To the Hospital or Attendi<br>within 24 hours after death.  To the Funeral Director: completely filled in by the fi   | Certification: | 3 Suicide 6 Could not be determined (Specify) unkn   |                        |   |                   | 28f. Location (St<br>or Town, Sta                          |                                      | Rural Route Number, City                            |
| thin 24 hc<br>the Func<br>npletely f  | Medical C      | 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination  |                        |   |                   |  |                                      |   |
| To Wit  | Mec            | 29b. Signature and title of certifier  |                        | 29c. License n                              | umber             |  | 29d. Date signed (N                  | fonth, Day, Year)                                   |
| a. (L   |                | 0-21-  |                        | O.C.M.                                      | E.                |  | May 4, 2012                          |   |
| x berg  |                | Name and address of person who completed cause of death (I     Donna M. Vincenti, MD Assistant Medical Ex  |                        | V. Baltimore S                              | treet, Baltimo    | ore, MD 212  | 23                                   |   |
|   | tate           | 31. Date filed (Month, Day, Year) 32. Registrar's Sign   |                        |   | ,                 |  |                                      |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 14861 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Annabelle Wright Harris May 9 1:20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6 Upland Road, N/AApt. J2 Baltimore If Under 5. Social Security Number Year If Under 24 Hrs Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Director 212-34-0083 1 🗆 M 2 💢 F 78 May 16,1933 Pennsylvania Usual Residence of Dece show 10a. State aţ 10c. City, Town or Location 10d, Inside City Limits Director notified or 28a-f 1 🛱 Yes 2 □ No N/A Marvland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 21210 6 Upland Road, Apt. J2 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. or Completed by 1 Never Married 2 Married 1 Yes Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", White 3 Widowed 4 X Divorced Specify. Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) traumatic event, the Corporate Dir. of Nursing International Paper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I marked o ည Frederick Charles Harris Isabelle McClullich and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Virginia Harris/Daughter 506 Broad Creek Loop Rd., Newport, NC 28570 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State ō Department of Important: If any injury or once. 05/10/2012 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 Signature of Funeral Service Licensee Alyson K Taylor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Houde monas Medical **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury sician and burial-transit Due to (or as a consequence of): that initiated events resulting in death) Last physician Division of Vital Records, P.O. Box 68760  $^{ extsf{C}}$ Physician/Medical the as attending IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 menths?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 2 No 1 Yes Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Natural iniury 5 Pending 1 Yes 2 No Accident Investigation Funeral Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier To the Hosp within 24 hou To the Funel completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practifioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar

0

7143

Baltime MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(zoline St

32. Registra's Sign

DNIGHT WOOSLOT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Erle Manning Hutchins May 5, 2012  $3:00p^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 8 Mc Gregor Way Harford Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) 239-46-8382 1 X M 2 □ F **Director** 83 Dec. 15,1928 North Carolina item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2X No Maryland Harford BelAir 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 8 McGregor Way 21014 USA 12. Was Decedent Ever in Armed Forces? 1 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1952-Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1954 1 ☐ Yes 2 X No Specify. Specify: White 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) Mechanical Engineer T3TA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H permit. Page 1 and 2 should be a Department of Health and Mental Important; I item 27 is meany injury or other. Ernest Temple Hutchins Maude Pulliam 19a. Informant's Name/Relationship (Type, Print)
Mary Lee Hutchins/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 McGregor Way BelAir,Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 DRemoval from State Metro Crematory, Inc. 5/8/2012 Baltimore.Maryland 4 ☐ Donation 5 ☐ Other (Specify) Custer 22. Name and Address of Facility Cremation Society of Maryland, Inc 21. Signat ne of Funeral Service Licensee Stephante 299 Frederick Road Baltimore, Maryland 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of as the burial-transi and Due to (or as a consequence of): attending physician or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Yes 2 No eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached i 9 Unknown Division of Vital Records, P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? after death.

Director: After this certificate Yes 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28c. Injury at work? 1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred iniury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29h. Signature and title of cert 29d. Date signed Month, Day, Year, who completed c use of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9,15,16a&b Maryland Department of Health and Mental Hygiene amend #20a-c &22 Per FH G92/5/29/2012 JH Certificate of Death 1 - For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month OH 0603 M **Physician** HUDNALL HOMAS /Medical 4c. County of Death 4b. City, Town, or Location of Death
BALTIMORE 4a. Fecility Name (If not institution, give street and number) Examiner BALTIMORE SECOURS 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign County) 17, 1959Weat Virginia If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Numbeank **Funeral** Days Hours Months 1**∑**M 2□F Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a. State 28a-f show Examiner must be notified at 1 Yes 2 No MD Washington Hagerstown Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 18601 Roxbury Road 21746 USA items 23a death Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Black, White, etc. filed within 72 hours after ☐Yes 2 Yes, Give 1 Never Married 2 Married ö 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Specify: white 3 Widowed 4 Divorced Year or Dates: natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry The Mudical 15. Decedent's Education (Specify only highest grade completed) unk <del>unk</del> other than Elementary/Secondary (0-12) College (1-4or 5+) unk 0 unk Roofing &Fencing Home Improvement unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be h and Mental I Pages 1 and 2 should be nent of Health and Mental ant: If item 27 is marked o Roy Hudnall Wilma Sue Coble 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2000 W. Baltimore Street Baltimore, MD 21223

20b. Place of Disposition (Name of cometery, crematory, or other place)

Atlantic Communication of the place of the Bon Secours Hospital Wilma Sue Hudnall- mother 20a. Method of Disposition
1 ☐ Burial 22 Gremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 5/24/2012 Glen Burnie,MD Atlantic Crematory `4 □Donation 5 ₩ Other (Specify) in state 21. Signal to of Funeral Service Licensee Ronald, Service 22. Name and Address of Facility Simplicity Cremation & Funeral Service Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21076

Approximate

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** FALLRE KIDNEY sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine IRRHOSIS Atteniding Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ RESPIRATORY FAILURE 1 Yes 2 No 3 Probably 4 Unknown icate has been sig Be Completed THROM BOCYTOSU 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? COAGULOPATHY ₹ No certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Direct ò Hospital peril 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Chack only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number D70720 SIDD(3-M e ed cause of death (Item 23a) (Type, Print) 30. Name and address of 2000 W. BALTIMOKE ST. BALTIMORE, MD AHSAN M.D. parke 32 Registrar's Signature 31. Date filed (Mo

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death **Physician** 7017 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Battimore Breltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State 8. Date of Birth (Month, Day, **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) 1 M 2 F Hours Min 23 -7379 Director Marylane Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No Completed by Funeral Director MO Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 402 Union 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No White 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ LAKNOWA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberle 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra 20a. Method of Disposition Inother Bu Union Cive 1timore 21211 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 5/11 21. Signature of Fune Brad bey-Ashton Funeral 2134Willow SpringRd 2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a sonsequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To nours after death.

neral Director: After this filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 □ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Month Allan G. Hope 20 3;15 PM M April Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 104 Poplar Hill Avenue Wicomico Salisbury 5. Social Security Numberunk | 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 1**X** M 2 □ F 65 July 11, 1946 Canada Usual Residence of Deceden or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD Wicomico Salisbury 1 Yes 2X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be r Funeral 104 Poplar Hill Avenue Canada "natural", or items dical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. fitem 27 is marked other than "natural", or other traumatic event. The Maximal Ferrical þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. white 3 X Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 4 <u>downtown revitalization</u> planning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Patterson/friend 6162 Westbrooke Drive Salisbury, MD 20a. Method of Disposition 20b. Place of Disposition (Name of . If it 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Department of Important: If any injury or 4 ☐ Donation 5 🕅 Other (Specify) jn state <sup>22</sup> Name and Address of Facility.
State Anatomy Board 655 W. Baltimore Street Director Raltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last a: ending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live Birth 2 ☐ Fetal dea:
4 ☐ Pregnant at time of death
9 ☐ Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 Hospital or Attending Physician: ' !4 hours after death. Funeral Director: After this certific 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗆 No Investigation 6 Could not be filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical

State Registrar 29a. Certifier

29b. Signatu

(Check

only one

31. Date filed (Monti

Ce

30. Name and address of person who

tifying

DME

0.0

mpleted cause of death (Item 23a) (Type, Print) 100

To the Pwithin 2.

E Carroll

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Jalishun

29d. Date signed (Month, Day, Year)

4/30/12

21801

Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

450497

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 14866 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Humphries Month 2012 bseph 1420 P 05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death center-Genesis Multi- medical Baltimore TOWSON Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 161-01-7692 Hours March Day Ye Director 1 ★ M 2 □ F 93 Yrs. Pennsylvania Usual Residence of Decedent 1919 28a-f show the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Towson Maryland 1 Yes 2 X No 10e. Street and Number 9 10f. Zip Code must be r 10g Citizen of What Scuntoves Funeral 21204 22 Dunvale Road Apt. A of America Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 

X Yes 2 

No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. an "natural", or iter Medical Examiner þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) er than the Me Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Diebold Electrician 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Olive Fisher ည John Humphries 19a. Informant's Name/Relationship (Type, Print)
Grace E. Humphries/ wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 22 Dunvale Road Apt. A Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel Bel Air 20a. Method of Disposition May 8, 2012 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Faneral Service Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Peritonitis Probable disease or condition Medical resulting in death) Examiner Acute Sequentially list conditions, if any cause Enter Underlying Examiner attending physician and I for use as the burial-transit intestinal Cause (Disease or injury that initiated events resulting in death) Last Gastro infection Due to (or as a consequence of Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Anemia, Progressive Completed 1 ☐ Yes 2 ☐ No 3 🂢 Probably 4 ☐ Unknown cancer, chronic obstructive Pulmonary disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 1 Yes 2 🔀 No within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred ✓ Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D71493 05/07/2012

DHMH 17 Rev 06-2011

State

Registrar

TOWSON, MD

York Rd.

21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7700

31. Date filed (Month, Day, Year)

MAY 1 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 4867 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Monthy Ay RGIN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore County Towson Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 214-38-2081 May 20, 1941 **Director** 1 □ M 2 🕇 F 70 Roandke Rapids, N.C. Usual Residence of Decede 10a. State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Pennsylvania York County New Freedon 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16143 Sherwin Court 17349 United States filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ö 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 KNo Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) **N/A** Home Maker Own Hame Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ! t. Page 1 and 2 should be fill thent of Health and Mental rant: If item 27 is marked of ၉ Roy Elmo Hargrove Bertha Mae Hatchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Elaine Johnson (Daughter 16143 Sherwin Court New Freedom, PA. 17349 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State (Harford County) 1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State Example of the state of the sta Wednesday, May 09,2012 Department or Important: If any injury or once. injury or 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. O. 22 Name and Address of Facility Service Funeral and Cremetion Center, P.A.

12 Name and Address of Facility Service Funeral and Cremetion Center, P.A.

12 Name and Address of Facility Service Funeral and Cremetion Center, P.A.

12 Name and Address of Facility Service Funeral and Cremetion Center, P.A.

12 Name and Address of Facility Service Funeral and Cremetion Center, P.A.

12 Name and Address of Facility Service Funeral and Cremetion Center, P.A.

12 Name and Address of Facility Service Funeral and Cremetion Center, P.A.

12 Name and Address of Facility Service Funeral and Cremetion Center, P.A.

12 Name and Address of Facility Service Funeral and Cremetion Center, P.A.

12 Name and Address of Facility Service Funeral and Cremetion Center, P.A.

12 Name and Cremetion Center, P.A.

12 Name and Cremetic Funeral and Cremetic Funeral and Cremetic Funeral Address of Facility Service Funeral and Cremetic Funeral Address of Facility Service Funeral Address of Facil complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final et and Death Physician/ TASTATIC 110 disease or condition CASTRIL Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be a Sy brours after death.
• Funeral Director: After this certificate has been signed by the attending physicia is Funeral Director. After this certificate has been signed by the attending physicia is Funeral director, page & should be detached for use as the burnelielely filled in by the funeral director, page & should be detached for use as the burnelielely. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months 1 Yes 2 No 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, ement A Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown SCLORUTE CARDIOVASCULAR 24a. Was an Were autopsy findings available prior to completion of cause of autopsy 1 🗆 Yes 1 Yes 2 No 2 1 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No **Division of Vital** Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical within 24 hor To the Fune completely fi 29a. Certifier Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State MAY 1 0 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:40 AM Kaymond Herbert 20 1 Z Medical 4a. Facility Name (if not institution, give street and number)
4301 23rd Parkway Apt **Examiner** 4b. City, Town, or Location of Death 4c, County of Death Apt 910 corgo 7. Age (In yrs. last birthday) **Funeral** If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min 79-36-Director 1 M 2 - F 81 1930 NY 04-30-Usual Residence of Decedent 10a. State the Maryland 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits Prince or 28a-f MD Hills 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event. the Medical Evamina. Funeral 20748 Parkway US 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, : If item 27 is marked other than "natural", or i or other traumatic event, the Medical Examin Completed by 1 Never Married 2 Married Black, White, etc Baltimore, Maryland 21215-0036 1 Tes 2 No Specify 3 Widowed 4 Divorced If Yes, Give Specify: white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Industry rivate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Herran Kaymond Vaughn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reichardt Cousin 959 PU BOX 1749 Lawrence Quoque 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 05-09-12 4 ☐ Donation 5 ☐ Other (Specify) Crematory Kiver dal 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Tisha Home 4111 Pennsylvania Are Suitland, ND 20146 Kuneral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph, sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and I for use as the burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consent at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 🗆 Yes 2 🕽 No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has autopsy performed Yes 2 N page Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year, 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined within 24 hours after To the Funeral Direct Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and add ause of death (Iten Old Branch 6104 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14869 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician. May 6, 2012 Mary S. Jameson 10:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 709 Chapel Ridge Road Timonium Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 215-26-9454 81 1 - M 2 XX **Director** Aug 10, 1930 MD Usual Residence of Dec or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Baltimore Timonium 1 🗆 Yes 2 🗓 🗓 10e. Street and Numbe 10f. Zip Code ms 23a or must be r 10g, Citizen of What Country? Funeral within 72 hours after death with 709 Chapel Ridge Road 21093 U.S.A. or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∰No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Examiner Black, White, etc 1 Never Married 2 XXMarried þ Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify. ian "natural", e Specify 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumatic event, the I +4 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Kane Smart Angela Dorsey Getty 19a. Informant's Name/Relationship (Type, Print)
Joseph C. Jameson, III (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 709 Chapel Ridge Road Timonium, MD 20a. Method of Disposition
1 □ Burial 2 ★ remation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20c. Location - City or Town, State Date 5/12/2012 Glen Burnie, MD 4 Donation 5 Other (Specify) e of Funeral 22. Name and Address of Facility Home of Dulaney Valley, Inc. O West Padonia Road Timonium, MD 21093 23a. Part 1. Enter the disease, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CANCER REASI disease or condition resulting in death) Llars Medical **Examiner** CORONARY Sequentially list conditions, if any, leading to humodiate cause. Enter Underlying Cause (Disease or injury requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death the 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown plnous Completed Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 
Nursing Home 5 Residence 6 Other (Specify) hours after death.

Ineral Director: After this of filled in by the funeral directorials. 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 24 within 2 To the I 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2012 D46988

State

31. Date filed (Month, Day,

MAY 1 0 2012

MD

32. Registrar's Signature

2501

MEDICAL

OSLER

ONCOLOGIS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

421

TOWSON

21204

|                            |  |                  | State Registrar   |  | ,                | Cer                  | tificate                                       | of Death   | 7                    | ,                               | Reg. No.        |   |  |  |  |  |
|----------------------------|--|------------------|---|--|------------------|----------------------|--|--|----------------------|---------------------------------|-----------------|---|--|--|--|--|
|                            | Physicia   | an/              | 1. Decedent's Name (First, Middle, L  | ,  |                  |                      |  | -  |                      | 2. Date of De<br>Month          |                 | Vear  | 3. Time of Death                                   |  |  |  |
| Medical                    |  |                  | Denice Ann Kell   |  |                  |                      | May  | 7, 2   | 2012 <sup>Year</sup> | 5:40 P                          |                 |   |  |  |  |  |
|                            | Exami  | ner              | 4a. Facility Name (if not institution, gi   |  |                  |                      |  | wn, or Locatio   | n of Death           |                                 | 4c. Co          | unty of Death   |  |  |  |  |
| -                          | Forest   |                  | 16147 Ed Warfie 5. Social Security Number 6.  |  | ge (In yrs. last | hirthday             | WOOC<br>If Under 1                             | bine   | ler 24 Hrs.          | 8. Date of Bir                  |                 | Howard  |  |  |  |  |
| ш                          | Funeral<br>Director  |                  |   | 1 M 2 F  |                  |                      |  | Days Hours   |                      | (Month, Da                      | y, Year)        | Cour  | place (State or Foreig<br>ntry)                    |  |  |  |
| 4                          |  | 1                | Usual Residence of Decedent   |  | 45               | Yrs.                 |  |  |                      | Sept 2                          | 4 <b>,</b> 1966 | Tex   | as   |  |  |  |
|                            | /land<br>f sho   | 후                | 10a. State 10b. County  |  | 1                | Town or Loc          |  |  |                      |                                 |                 |   | 10d. Inside City Limits                            |  |  |  |
|                            | Many<br>28a-i<br>otifie  | ie               | MD Howar  | rd   | Woo              | odbine               | 3  |  |                      |                                 |                 |   | 1 🗆 Yes 2 🕦 N                                      |  |  |  |
|                            | th the   | <u>a</u> □       | 10e. Street and Number  |  |                  |                      | 10f. Zip C                                     |  |                      |                                 | 9               | of What Cou   | ntry?  |  |  |  |
|                            | th wit<br>ms 2;<br>must  | Funeral Director | 16147 Ed Warfie   |  |                  |                      |  | 21797  |                      |                                 |                 | USA   |  |  |  |  |
| 36                         | 2 hours after death with the Maryland<br>"natural", or items 23a or 28a-f show<br>edical Examiner must be notified at  | Completed by Fu  | 11. Marital Status  1  Never Married 2 X Married  | 12. Was Decedent Armed Forces? 1  Yes 2 If Yes, Give |                  | If                   | Yes, specify                                   | t of Hispanic (<br>Cuban, Mexid                        | can, Puerto          | cify Yes or No-<br>Rican, etc.) |                 | Race - Americ<br>Black, White,  |  |  |  |  |
| 9                          | ours<br>atura  | etec             | 3 Widowed 4 Divorced  15. Decedent's  | Year or Dates.                                       | 1                |                      |  |  |                      |                                 |                 | Whi   |  |  |  |  |
| 5                          | 72 h<br>in "nis<br>Medic   | nple             | (Specify only highest   | grade completed)                                     |                  | (Give k              | ent's Usual (<br>ind of work (<br>) NOT use re | lone during m  | ost of worki         | ng                              | 16b. Kind o     | of Business/In  | dustry   |  |  |  |
| 212                        | vithin<br>jene.<br>jr tha<br>the f   | ပိ               | Elementary/Secondary (0-12)   | College (1-4 or 12                                   |                  | Homen                |  | tiroa)   |                      |                                 | Ownh            | ome   |  |  |  |  |
| þ                          | illed vall Hyg   | Be               | 17. Father's Name (First, Middle, Last  |  |                  | 11011101             |  | 18. Mc   | ther's Name          | e (First, Middle,               |                 |   |  |  |  |  |
| Maryland 21215-0036        | ge 1 and 2 should be filed within 72 hour<br>nt of Health and Mental Hygiene.<br>If item 27 is marked other than "natul<br>or other traumatic event, the Medical   | 욘                | Douglas Dillard   | ł  |                  |                      |  | cl   | risty                | Jo Hei                          | rbsleb          |   |  |  |  |  |
| an                         | should<br>and N<br>is ma   |                  | 19a. Informant's Name/Relationship  | (Type, Print)  |                  | 19b. Mailin          | g Address (S                                   | treet and Num  | ber or Rura          | l Route Numbe                   | r, City or Tow  | n, State, Zip (   | Code)  |  |  |  |
|                            | nd 2 sealth m 27   |                  | Paul Keller / hu  | ısband   |                  | 16147                | 7 Ed W   | arfield  | d Road               | d Woodb                         | ine, M          | D 2179  | 7  |  |  |  |
| Baltimore,                 | e 1 a<br>of H<br>if itel   |                  | 20a. Method of Disposition  1 Darial 2 Cremation 3  | Removal from State                                   |                  | e of Dispos          | sition (Name<br>atory or othe                  | of<br>er place)  | [                    | Date                            | 20c. Locati     | on - City or To   | own, State   |  |  |  |
|                            | Pag<br>ment<br>tant:<br>jury o   |                  | 4 Donation 5 Other (Spe   |  | [Final           | L Jour               | ney C  | remato   | ry 5/1               | 0/12                            | Wood            | bine, 1   | MD   |  |  |  |
|                            | permit. Page 1 a Department of F Important: If ite any injury or ot  |                  | 21. Signature of Juneral Service Lice   | nsee   | M0165            |                      |  |  |                      | n Serv                          |                 |   | 784<br>- MD 2102                                   |  |  |  |
|                            | Physician/<br>Medical<br>Examiner  |                  | 23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, | one cause on each lin                                | e.               | colon                |  |  | as cardiac d         | r respiratory an                | rest,           | 2   | Approximate Interval Between Onset and Death Years |  |  |  |
| 8760                       | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burral-transit | Medical Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | a consequen      |                      |  |  |                      |                                 |                 |   |  |  |  |  |
| Box 6                      | ne death certific<br>/ the attending p<br>ched for use as  | by Physician/Me  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🕱 No g ☐ Unknown   | 23c. If yes, outcome 1  Live Birth 4  Pregnant a     | 2 ☐ Fetal de     | eath 3 🔲             | Ectopic predother (special                     |  |                      |                                 | 23d.            | Date of delive  | ery<br>Day Year                                    |  |  |  |
| P.O.                       | that the   | y P              | Part II. Other significant conditions   | contributing to death b                              | out not resulti  | ng in the un         | derlying cau                                   | se given in Pa   | rt 1.                | 23e. Did to                     | obacco use c    | ontribute to th   | ne cause of death?                                 |  |  |  |
|                            | uires<br>n sign  | pe               |   |  |                  |                      |  |  |                      | 1 🗆 '                           | Yes 2 🛛 N       | o 3 🗆 Prol  | pably 4 🗆 Unknow                                   |  |  |  |
| Division of Vital Records, | The law requires<br>ate has been sig<br>page 2 should b  | Completed        |   |  |                  |                      |  |  |                      |                                 |                 | 1b. Were autoprior to codeath?  | osy findings available mpletion of cause of        |  |  |  |
| a                          | sian:<br>ertific<br>ector,   | Be (             | 25. Was case referred to medical examiner?  |  |                  |                      | - 2  | 26. Place of D   | eath (Check          |                                 |                 |   |  |  |  |  |
| Š                          | hysic<br>his co<br>al dire   | 은                | 1 Yes 2 X No  |  | ient 2 🗆 ER      |                      | 3 🗌 DOA  | Other: 4   | Nursing Ho           | me 5 🗷 Resid                    | dence 6 🗆 0     | Other (Specify  | )  |  |  |  |
| υot                        | ling P   | ate:             | 27. Manner of Death 1   Natural 5 □ Pending   | 28a. Date of inju<br>(Month, Da                      |                  | b. Time of<br>injury |  | 28c. Injury at work? 28d. Describe how injury occurred |                      |                                 |                 |   |  |  |  |  |
| visior                     | or Attend<br>ifter death<br>irector: /   | Certificate:     | 3 ☐ Suicide 6 ☐ Could not   | 2 Accident Investigation 3 Suicide 6 Could not be    |                  |                      |  |  |                      |                                 |                 | Yes 2 No  28f. Location (Street and Number or Rural Route Number City or Town, State) |  |  |  |  |
|                            | Hospital 24 hours a Funeral C  | Medical (        | (Check 2 L Medical Exar   | ysician: To the best of niner: On the basis of e     | examination an   | nd/or investi        | nation, in my                                  | opinion, death   | occurred at          | the time date a                 | nd place and    | due to the car  | ise(s) and manner stat                             |  |  |  |
|                            | To the<br>within<br>To the<br>compl  | 2                | 29b. Signature and title of certifier   | rse Practitioner: To th                              |                  |                      | 29c. Li  | cense number   |                      |                                 | 29d. Date sig   | ned (Month, I   | Day, Year)   |  |  |  |
|                            | 5 v  |                  | 30. Name and address of person who  | completed cause of d                                 | leath (Item 23   | (Type, Pr            | int)<br>Roo                                    | m Yl   | noc,                 | Bal                             | hore            | MI  | 2/287  |  |  |  |

DUMU 17 Day 06 2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1487 For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 05 13:4213 Helen M. Lane 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** Saltimore MD n/a Agner HOSPITON 5. Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 6. Sex 7 Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Hours 220-22-26 19 **Director** 1 M 2 XF Yrs. 8/20/1929 Maryland 82 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c, City, Town or Location Director notified 28a-f 1 Yes 2 X No Catonsville MD Baltimore 10e. Street and Number 10g. Citizen of What Country? ò ms 23a or must be Funeral 709 Maiden Choice Lane, RGT 306 21228 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 ☐ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ntal Hygiene. ed other than " event, the Mee Elementary/Secondary (0-12) College (1-4 or 5+) Printing Secretary permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth, any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Koenig Grace Wilhelm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 Greenland Beach Road, Curtis Bay, MD 21226 POA Susan Spurling-Marcus/ 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Donation 5 Other (Specify) 5/9/2012 Meadowridge Mem. Pk. ELkridge, Maryland e of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, MD 21229 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 0 P disease or condition Medical resulting in death) Due to (or as a consequence of): Years **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death Day be detached the g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed plnous been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 N , page 2 s has this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) · 1 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Director: After 1 Matural 5 Pending Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P264 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Mantrola lotigro H Aques 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State MAY 1 0 2012 Registrar √ DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 14872 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Keun Physician/ loung 15:05 PM May 2012 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1-8455 Min (Month, Day, Director 1 M 2 D F 1926 6 Orea Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits Director towari allte 1 Yes 2 No 10e Street and Number 0 10g. Citizen of What Country? Funeral I 23a 868 NO 0 OWRR permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or ite Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Asian Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1 4 or 5+) the TOVERNMON! Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H item 27 is marked ot other traumatic even 2 UNK UWK 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 368 Lower MUTE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important; If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) TeS1 awn 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Howe ittok 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SepticShock Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner weeks ator Associate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine weeks Distress Syndrome the burial-transit Respiratory Cause (Disease or injury that initiated events resulting in death) Last and attending physician weeks Pheumonia enotrophomonos Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year signed by the at d be detached for Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: Enterobacter Chaae Preumonia performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospita Other: ျှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending ✓ Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one) Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D0062273 MD 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 Cedar Lane Columbia, MD 21044 Amin Shahriar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 5 James C. Monk May 0151 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Yea an 5 , 19 1 X M 2 D F Hours Min. Director Yrs. 246-60-6594 1941 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Medical Examiner must be notified at 10d. Inside City Limits Director 1 XYes 2 No DC Washington 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 4339 Bowen Road, SE #313 20019 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò þ 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Sale<u>sman</u> 12 Government and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Leonidas Monk Tokie Williams traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health are Important: If item 27 is any injury or other trau P.O. Box 5299 Suffolk, VA Pamela Richard/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5/15/12 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Heritage Mem. Cemetery 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licenses 3910 Silver Hill Rd., Suitland, MD. 20746 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner RESPIRATURY FAILURE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ARTERY DISEASE ORONARY use as the burial-transit resulting in death) Last Due to (or as a consequence of): KIDNEY DISEASE Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown detached g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ANEMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law page 2 performed certificate 2 X No Yes 2 No 1  $\square$  Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 X No 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 I this 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 5 Pending 1 Natural 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2. MD52855 Chandras elelo 4 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) -B Hanover PKWY, Greenbelt, MD 20770

Registrar

State

DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 2:35 A M Helen B. MacDermott Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 0235 Days Hours Min. Country **Director** 577-07-1856 1 🗆 M 2 🔀 F 101 May 4, 1911 Washington, DC Usual Residence of Deced show 10a State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 X No MD Montgomery Montgomery Village ò 10e. Street and Number 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 19310 Club House Road #323 20886 United States MAY 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 XWidowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ELEN (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Dental Assistant Dentist Office and Mental Hygier is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) t ပ traumatic Edward O. Zeigler Katie Horman 19a. Informant's Name/Relationship (Type, Print) NACOCK MOT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 Paul H. Eshenbaugh / Nephew 15108 Falconbridge Terr. North Potomac, MD 20878 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 1 
Burial 2 
Cremation 3 
Removal from State Department or Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 5/11/2012 Woodbine, Maryland 21. Signature uneral Service Licensee Going Home Cremation Service P.O. Box 784 MO1651 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. moumonin aspironon disease or condition Medical resulting in death) Due to 4 r as a consequence of Examiner demention Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events y CANS The to for sels none queries by Exami pheral veinous insufficiency UCRIV5 and -trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical death certificate be Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ ō Month Day Pregnant at time of death Unknown 9 Unknown Division of Vital Records, P.O. à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 🗗 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed or Attending Physician: The certificate I Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 V No Other: |은 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred s after dea... ral Director: Afte 5 Pending injury work?
1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certified 29c License number 29d. Date signed (Month, Day, Year) Alsell May 3, 2010 231391 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Proderick tre, Gaithersburg, Maryland 20877 Suhair Abulfarag MD 604 South

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Villiam Issac Mansor 12:20 AM May Medical 8 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death SINAL HOSPITAL OF BALTIMORE NIA BALTIMORE 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours 212-22-0357 (Month, Day Country **Director** 1 **X** M 2 □ F NC. 02 Usual Residence of Decedent 28a-f show 10a. State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Randallstown MD 1 ☐ Yes 2 No 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 21133 Brenbrook ASA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Rlack. White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced "natural" Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore County Elementary/Secondary (0-12) College (1-4 or 5+) Chief Custodian Board of Education 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mack Susie) Hunter Manson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health WIFE Hard helma Drive Randallstown MD 21133 Brenbrook Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State
Windsor Mill, Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial park 15 2012 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses C. Greene Funeral Services 22. Name and Address of Facility Vauahn oad Kandallstown MD 21133 23a. Part 1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, of heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause Final Physician/ RESPIRATORY FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner FAILURE HEART CONGESTIVE Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) executed PULMONARY EMBOLISA Cause (Disease or injury and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 24a. Was an this certificate has autopsy perform 1 ☐ Yes 2 🗙 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes Other: HOSPICE 2)4 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending Investigation
6 Could not be Accident 24 hours after deatl Funeral Director. 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Definition in the desir of the desir of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) MA RES 000 May 8 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIJEN JOSHI MD SINTAL HOSPITAL OF BALTIMORE 2401 W BELYEDERS AVE, BALTIMOREMD2/215 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

X DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death tu Month Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Square Hospital 4c. County of Death BAltimore ROSEDAle **Funeral** 6. Sex If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth 9. Birthplace (State or Foreign **Director** (Month, Day, or 28a-f show notified at 10a. State Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No must be 23a Funeral 10g. Citizen of What Country? CANDLE 21237 USA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ō Completed by 1 Newer Married 2 Married Maryland 21215-0036 Yes Yes Yes. Give Black, White, etc. 2 No "natural" 3 ☐ Widowed 4 ☐ Divorced Year or Dates White other traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Home OWN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 05c Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of uneral Service License 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Physician/ Interval Between Onset and Death Medical **Examiner** OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery Pregnant at time of death Yes 2 Month Day Year g 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sum. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed upletely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes ျှ Hospital Other: 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certificate: 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) ✓ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 ✓ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 ✓ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number D39758 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WEVIN Schendel MD-GILH Philadelphia RD, Shite 300 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #9, II, 12, 15, 16a&b, 17, 18&19a&b, Per, ANA, BD, G928, 6/06/2012 State of Maryland, Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month' Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death If Under 24 Hrs. 6. Sex If Under 1 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 226-44-5559 1 M 2 □ F **Director** Virginia May 10, 1937 ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2519 Oswego Avenue 21215 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11 unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2XXMarried þ Baltimore, Maryland 21215-0036 within 72 hours after unk 1 ☐ Yes 2 X No Specify: black. Completed 3 Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk unk 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) marked other than Elementary/Secondary (0-12) Laborer Shipyard Be 17. Father's Name (First, Middle, Last) unk unk 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o ည George Martin Thelma Martin 19a. Informant's Name/Relationship (Type, Print) **Belinda Martin – daughter University of MD Medical Ct** Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Lombard ST. Baltimore, MD 21201

Creene Street Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other placel 4 Donation 5 N Other (Specify) in state Licensee S Way of Funeral Servi <sup>2</sup>State<sup>nd</sup> Addas රැසිදු<sup>ilit</sup>Board 655 W. Baltimore Street 21201 MD 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final disease or condition Onset and Death Ph sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events executed burial-tran resulting in death) Last to (or as a consequer physician s the burial Physician/Medical that the death certificate be P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ P in the past 12 months? Day Year Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Physician: The law requires 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed?

1 Yes 2 No 1 Yes 2 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 🗌 No 1 Yes မ 1XInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending injury Natural 5 Pending s after death. M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide completely filled in by determined 24 hours a Funeral I Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 3 only one) 29b. Signature and title of certifier 29c. License number P 2733 MD April 23, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) byene St. Ba Ny-Ying Lam

DHMH 17 Rev 06-2011

State Registrar

Davs Hours **Director** 002-40-0629 1**X** M 2 □ F Yrs 61 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Director must be notified MD Prince George's Suitland 10e. Street and Number 10f. Zip Code Funeral items 23a 4641 Burnett Avenue 20746 12. Was Decedent Ever in U.S. Armed Force ? 1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ö by Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 laborer other traumatic event, Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. မ Joseph Mulvey 19a. Informant's Name/Relationship (Type, Print) Sylvia Sullivan/friend 20a. Method of Disposition 20b. Place of Disposition (Name of ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 X Other (Specify) in state 21. Signat re Funeral Service Licensee Ronald S Waste Pirector 23a. Part 1. Outer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ph\_sician/ ASPIRATION PNEUMONIA Medical Due to (or as a consequence of): **Examiner** Acute Alcohol Intoxication Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and that initiated events resulting in death) Last physician ar Due to (or as a consequence of): Physician/Medical Box 68760 as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: ISe 23b. Was decedent pregnant for in the past 12 months? 2 No Yes the 9 Unknown 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by OBSTRUCTUE PULMONARY DIS EASE CHRONIC Records, To Be Completed 24a. Was an Cocaine Use has autopsy performed Yes 2 s certificate has lirector, page 2 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Division of Vital 26. Place of Death (Check only one) Hospital Other: Inpatient 2 - ER/Outpatient 3 - DOA 27. Manna of Death Certificate: 28c. Injury at work? 1 ☐ Yes 2 🗷 No Date of injury (Month, Day, Year) 28b. Time of 5 Pending iniury 2 X Accident Investigation  $7:59 p^{M}$ 4-26-2012 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Garage within 24 hours a Medical 29a. Certifier To the within 29b. Signature and title of certifier 00064986

For State Registrar

Physician/

Medical

**Examiner** 

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (if not institution, give street and number)

Francis Mulvey

Southern MD Hospital Clinton Prince George's 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 13, 1950 Rhode Island 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White/etc. white Specify. 16b. Kind of Business/Industry construction 18. Mother's Name (First, Middle, Maiden Surname) unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5116 Fable Street Capitol Heights, MD 20743 20c. Location - City or Town, State 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Approximate Interval Between Onset and Death 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \sum \) Yes 2 \( \sum \) No 4 Nursing Home 5 Residence 6 Other (Specify) 28d Describe how injury occurred subject ingested alcohol and self-administered cocaine 28f. Location Street and Numb 5 n Jaman 1 hors o Pik. City or Town, State 3368 A. N. Chatham Rd Ellicott City, MD. Suitland, MD. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 5/1/2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 31. Date filed (Month, Day, Year) State Registrar MAY 1 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 23a. pt. 1 b. pt. 11.27. 28a-f. per me. 2943 17-13 sm

State of Waryland / Department of Health and Mental Hygiene

Amend 281, per me. 2943 9-26-13 sm

Certificate of Death

Reg. No. 20 2

4b. City, Town, or Location of Death

2. Date of Death

April 30, 2012

4c. County of Death

6:49 AM M

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                            |  |                  | For  | State of  | of Marylan                            |                                  | artment of H  |                                       | Mental Hygi   | ene o                          | 210                            | 11070   |  |  |  |
|----------------------------|--|------------------|--|---|---------------------------------------|----------------------------------|---|---------------------------------------|---|--------------------------------|--------------------------------|---|--|--|--|
|                            |  |                  | State<br>Registrar   |   |                                       | Cer                              | tificate of D   | eath                                  | Re  | g. No. 2                       | 112                            | 14879   |  |  |  |
|                            | Physicia   | n/               | 1. Decedent's Name (First, Middle  | ueline  | Mitch                                 | 0.11                             |   |                                       | 2. Date of Death<br>Month   | Davi                           | Year                           | 3. Time of Death                              |  |  |  |
|                            | Medic  | al               | 4a. Facility Name (if not institution,   |   |                                       |                                  |   |                                       | Month   | T .                            | 017                            | 8:48 1 M                                      |  |  |  |
|                            | Examin   | er               |  |   | iber)                                 |                                  | 4b. City, Town, or I  |                                       |   | 4c. County                     | y of Death                     |   |  |  |  |
|                            | Funeral  |                  | 710 N. Monro   | 6. Sex  | 7. Age (In yrs. la                    | ist birthday)                    | Balti<br>If Under 1 Year  | more If Under 24 Hrs.                 | 8. Date of Birth  | 1                              | 9. Birthp                      | lace (State or Foreign                        |  |  |  |
|                            | Director   |                  | 214-50-1643  | 1 □ M 2 🛣 F   | 65                                    | Yrs.                             | Months Days   | Hours Min.                            | (Month, Day, ) Apr 5,   |                                | Count<br>Mary                  | try)  |  |  |  |
|                            | D W  | _                | Usual Residence of Decedent  10a. State  10b. County   |   |                                       | , Town or Loc                    | otion   |                                       | ,   |                                |                                |   |  |  |  |
|                            | arylan<br>a-fsh<br>fied a  | 5                |  |   | Toc. City                             |                                  |   |                                       |   |                                |                                | 0d. Inside City Limits  1 Y Yes 2 No          |  |  |  |
|                            | or 28<br>noti  | Ë                | MD<br>10e. Street and Number   |   |                                       | Dart                             | imore   |                                       | 11  | g. Citizen of                  | What Cour                      |   |  |  |  |
|                            | with t   | eral             | 710 N. Monroe  | Street  |                                       |                                  |   | 21217                                 |   |                                | USA                            |   |  |  |  |
|                            | eath<br>tems<br>er mu  | Funeral Director | 11. Marital Status   |   | edent Ever in U.S                     |                                  | /as Decedent of His   | panic Origin? (Spe                    | ecify Yes or No-  |                                | ce - America                   |   |  |  |  |
| 98                         | ", or  | by               | 1 Never Married 2 Marr   | If You Civ  | 2 No                                  |                                  | Yes, specify Cuban  ☐ Yes 2 X No                                |                                       | rican, etc.)  | Bla:<br>Specify                | ck, White, e                   |   |  |  |  |
| 8                          | within 72 hours after death with the Maryland<br>gjene.<br>et than "natural", or items 23a or 28a-f sho<br>the Medical Examiner must be notified at  | Completed        | 3 ☐ Widowed 4 ☒ Divorced   | Year or Dant's Education  |                                       |                                  | ent's Usual Occupa  |                                       |   |                                |                                |   |  |  |  |
| 15                         | an "na<br>Media  | mpl              | (Specify only highe  | st grade completed)   |                                       | (Give k                          | ent's Osual Occupa<br>rind of work done du<br>ONOT use retired) |                                       | ing 1   | 6b. Kind of B                  | lusiness/Ind                   | lustry  |  |  |  |
| 212                        | withir<br>giene<br>er th   |                  | Elementary/Secondary (0-12)  | College (1  | )<br>)                                | st                               | ate of MD   | )                                     |   | proces                         | sor                            |   |  |  |  |
| D                          | tilled<br>tal Hy<br>d oth<br>event   | To Be            | 17. Father's Name (First, Middle, L  | ·   |                                       |                                  |   |                                       | e (First, Middle, Ma  |                                | e)                             |   |  |  |  |
| <u> </u>                   | should be filed what and Mental Hyg  | ٦                | Booker T. Til  |   |                                       |                                  |   | Henrie                                | tta Scal  | es                             |                                |   |  |  |  |
| Maryland 21215-0036        | 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.  Health and Mental Hygiene.  The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | - 8              | 19a. Informant's Name/Relationsh<br>Leola C. Scale   |   |                                       | T.                               | g Address <i>(Street ar</i><br>N。 Monroe                        |                                       |   | -                              | State, Zip C<br>2121           | _ `   |  |  |  |
| d)                         | and 2 s<br>Health<br>Item 27<br>other tra  |                  | 20a. Method of Disposition   | 3/ 313001   | 20b. PI                               | <u> </u>                         | sition (Name of   | -                                     |   | 0c. Location                   |                                |   |  |  |  |
| Baltimore,                 | permit. Page 1: Department of I Important: If its any injury or ot   |                  | 1 Burial 2 Cremation 4 🕅 Donation 5 Other (S   | (necify)  | State C6                              | emetery, crem                    | atory or other place  | )                                     |   |                                |                                | ,   |  |  |  |
| ati                        | rmit. Partin<br>porta<br>porta<br>y inju   |                  | 21. Signature of Funeral Service L   | icenuce   | rector                                | 22,                              | Name and Address  | of Facility                           | d 655 W   | Rol+in                         | noro S                         | Stroot  |  |  |  |
| <u> </u>                   | 9 9 <b>5 6</b> 6   | - 4              | 1.20000  | TORE  | The Coop                              |                                  | altimore,   |                                       |   | Darti                          | nore s                         | Street  |  |  |  |
|                            |  |                  | 23a. Part 1. Enter the disease, or shock, or heart failure. List o   |   | Approximate<br>Interval Between       |                                  |   |                                       |   |                                |                                |   |  |  |  |
| P                          | Medical  | ė o              | Immediate Cause (Final disease or condition resulting in death)  a.  |   |                                       |                                  |   |                                       |   |                                |                                | Onset and Death                               |  |  |  |
| / .                        | Examiner   |                  | resulting in death)  | Due to  | or as a conseque                      | ence of):                        |   |                                       |   |                                |                                |   |  |  |  |
|                            |  | ner              | Sequentially list conditions,  | b. Dus to   | OF SEER CONFESCIO                     | anne cty:                        |   |                                       |   |                                |                                |   |  |  |  |
| 70                         | d<br>ansit   | ami              | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events   | G   |                                       |                                  |   |                                       |   |                                |                                |   |  |  |  |
| 000                        | nding physician and use as the burial-transit  | dical Examiner   | resulting in death) Last   | Due to (  | or as a conseque                      | ence of):                        |   |                                       |   |                                |                                |   |  |  |  |
| ၀                          |  | dic:             |  | d   |                                       |                                  |   |                                       |   |                                | _                              |   |  |  |  |
| 687                        | ding p   | /We              | IF FEMALE:   | 23c. If yes, out  | come of pregnan                       | ncv                              |   |                                       |   |                                |                                |   |  |  |  |
| Box                        | atten<br>I for u   | ciar             | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No   | 1 Live  |                                       | death 3 🗌                        | Ectopic pregnancy<br>Other (specify)                            |                                       |   | 23d. Da<br>Mo                  | te of delivery<br>nth Day Year |   |  |  |  |
| . n                        | been signed by the attending p<br>should be detached for use as  | Physician/Me     | 9 Unknown  | 9 🗆 Unkr  | nown                                  |                                  |   |                                       |   |                                |                                |   |  |  |  |
| O. ‡                       | gned b   | P P              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |   |                                       |                                  |   |                                       |   |                                |                                | bute to the cause of death?                   |  |  |  |
| ds,                        | en sig   | ted              |  |   |                                       |                                  |   |                                       | 1 🗆 Yes   | 2 🗆 No                         | 3 Prob                         | ably 4 Unknown                                |  |  |  |
| CO                         | as be  | Completed        |  |   |                                       |                                  |   |                                       | 24a. Was an autopsy   |                                | prior to con                   | sy findings available<br>npletion of cause of |  |  |  |
| å å                        | cate }   |                  |  |   |                                       |                                  |   |                                       | perform<br>1 Yes 2  |                                | death?<br>1 ☐ Yes :            | 2 🗆 No  |  |  |  |
| ital<br>E                  | certifi  | m                | 25. Was case referred to medical examiner?  1  Yes 2 No  | Hospital:   |                                       |                                  | Other   | ce of Death (Check                    |   |                                |                                |   |  |  |  |
| > \f                       | r this   | 은                | 27. Manner of Death  | 28a. Date   | Inpatient 2 E                         | ER/Outpatient<br>28b. Time of    | 28c. Injury   | 4 U Nursing Ho                        | me 5 Residen<br>28d. Describe how   |                                |                                |   |  |  |  |
| מיים                       | ath.<br>:: Afte  | icate            | 1 Natural 5 Pending<br>2 Accident Investig   | 9 .   | th, Day, Year)                        | injury                           | work?   | es 2 🗆 No                             | Lod. Boothise flow  | injury occur                   | cu                             |   |  |  |  |
| Division of Vital Records, | recto  | Certificate:     | 3 Suicide 6 Could r<br>4 Homicide determi  | ined 28e. Place   | of Injury - At hor                    | me, farm, stre                   | et, factory, office   |                                       | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |                                |                                |   |  |  |  |
| בֿ בֿ                      | urs af   |                  |  | 1   |                                       |                                  |   |                                       |   |                                |                                |   |  |  |  |
| Hoen                       | within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach   | Medical          | 29a. Certifier 1 Certifying (Check 2 Medical E   | Physician: To the be<br>xaminer: On the bas                                 | est of my knowle<br>is of examination | edge, death of<br>and/or investi | ccurred at the time,<br>gation, in my opinion                   | date and place, and death occurred at | nd due to the caus<br>the time, date and  | e(s) and manr<br>place, and du | ner as state<br>e to the cau   | d.<br>se(s) and manner stated.                |  |  |  |
| -<br>-<br>-<br>-           | vithin<br>To the   |                  | only one) 3 ☐ Certifying<br>29b. Signature and title of certifier  | Nurse Practitioner  | o the best of m                       | y knowledge,                     | 29c. License  | e time, date and pla<br>number        | ace, and due to the   | d. Date signe                  | nanner as st<br>d (Month, D    | ated.<br>Pay, Year)                           |  |  |  |
|                            | 71.0   |                  | > Ms/Lagay   | JOUNE IVIT  | )                                     |                                  | 00  | 05746                                 | 5   | 12/                            | 12                             | _   |  |  |  |
|                            |  | 1                | 30. Name and address of person v   | who completed caus  | e of death (Item :                    | 23a) (Type, Pr                   | int)  | 2- 1+n                                | 2-1 215   |                                | 7 00                           | 7   |  |  |  |
|                            |  |                  | NS Rayaya KS   | vaminer: On the bas<br>Nurse Practitioner  Who completed caus  Who 28  2012 | SI Smil                               | mM                               | 163 +   | >a 11/1/1                             | 1   | , 21                           | 1001                           | ′   |  |  |  |
|                            | Stat<br>Registra   | 9                | 31. Date filed (Month, Day, Year)  | 2012 32   | egistrar's Signatu                    | A L                              | alles .   |                                       |   |                                |                                |   |  |  |  |
|                            |  |                  | WIN A V  | 2012  | y man                                 | . 150                            | -   |                                       |   |                                |                                |   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) County of Death Town, or Location of Reath Examiner If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Social Security Number 1 Year 1 M 2 M F Months Days Hours Min. 03 aNI Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matter any once. 10b. Count 10a. State 10c. City, Town or Location 10d. Inside City Limits Director towar 1 🗆 Yes 2 🗹 No MOIA 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral Q 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: lack 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)  $0 \, YY$ tomema 2/2 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ၉ NNO. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mill. a claughter DUC 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other pla 0 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 2) DW 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line TATIC Immediate Cause (Final QUICER Physician/ METAS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Unit to (ur as a nunsiquence of): sician and burial-transit UIVISION Of VITAI Records, P.O. Box 68760 Library Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the a Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de Completed by 1 Yes 2 No 3 Probably 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 100 ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work? Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day Year) State Registrar

DHMH 17 Rev 7/2009

| 12-03490<br>Joseph Michael   |   | Please Ty   |                      |                                  | ind / Depa                           |                                     | f Health and                                |                                  |                          | Legibl                |  | 12                    | 1488                         |  |  |
|--|---|---|----------------------|----------------------------------|--------------------------------------|-------------------------------------|---|----------------------------------|--------------------------|-----------------------|--|-----------------------|------------------------------|--|--|
| Physicia   |   | Registrar  1. Decedent's Name (First, Midd                        | le,Last)             |                                  |                                      | tineate of                          | Death                                       |                                  | 2. Date of               |                       | ).   | 3. Time of            | Death                        |  |  |
| Medical Exami  | ner   | Joseph Michae   |                      | _                                | _                                    |                                     |   |                                  | Month<br>May 5           |                       | Year   | 1821                  | hrs                          |  |  |
|  |   | 4a. Facility Name (if not institution St. Agnes Hospital          | on, give stre        | eet and nui                      | mber)                                |                                     | 4b. City, Town, or<br>Baltimore             | Location of De                   | atn                      | 4                     | c. County of Dea   | /A                    |                              |  |  |
| Funeral  |   | 5. Social Security Number   | 6. Sex               |                                  | 7. Age (In yrs. I                    | ast birthday)                       | If Under 1 Year                             |                                  |                          | of Birth (MM          | I/DD/YYYY) 9. E  |                       | ate or                       |  |  |
| Director   |   | 212-86-6405   | 1∑M                  | 2_F                              |                                      | 49 Yrs                              | Months Days                                 | s Hours N                        | Min. July                | y 16,                 | 1962   | Country) Ice          | eland                        |  |  |
| any  |   | Usual Residence of Decedent<br>10a, State 10b, County             |                      |                                  | 10c. City,                           | Town or Locat                       | ion   |                                  |                          |                       |  | 10d. Insid            | e City Limits                |  |  |
| ahow :   | 5   | Maryland Baltimore Halethorpe                                     |                      |                                  |                                      |                                     |   |                                  |                          |                       | 1 Yes 2 No   |                       |                              |  |  |
| Maryl:   | Director  | 10e. Street and Number  |                      | 10f. Zip Code                    |                                      |                                     | 10g. Cit                                    | itizen of What Country?          |                          |                       |  |                       |                              |  |  |
| ith the 23a on notifie   |   | 1610 South Ro   |                      |                                  | edent Ever in U.                     | C 142 197                           | 2122<br>as Decedent of His                  |                                  | 0                        |                       | USA  |                       |                              |  |  |
| leath w  | Funeral   | 1 Never Married 2 N   |                      | Armed Fo                         |                                      |                                     | es, specify Cuban                           |                                  |                          |                       | 14. Race - Am<br>White, etc.   | erican indian,        | віаск,                       |  |  |
| after or   | by F  |   |                      | es, Give Year<br>Dates:          | г                                    |                                     | Yes 2X No                                   |                                  | _                        |                       | Specify: W   | nite                  |                              |  |  |
| 2 hours  | ted   | 15. Decedent's Education (Spe<br>Elementary/Secondary (0-12)      |                      | ghest grad<br>College (1         |                                      | 16a. Deceder<br>during m            | it's Usual Occupati<br>ost of working life. | ion (Give kind o<br>DO NOT use i | of work done<br>retired) | 16b.                  | Kind of Busines  | s/Industry            |                              |  |  |
| 036<br>ithin 7<br>rne.<br>r thao   | Completed   | 10  |                      |                                  | ,                                    | Cons                                | truction                                    |                                  |                          | St                    | ate Of 1   | Maryla                | nd                           |  |  |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other thao   |   | 17. Father's Name (First, Middle                                  |                      |                                  |                                      |                                     | 1   | 18.Mother's Na                   |                          |                       | Surname)   |                       | -                            |  |  |
| 212<br>uld be<br>Menta<br>marke  | To Be   | James C. Noppe  |                      |                                  |                                      | 19b. Mailing                        | Address (Street                             |                                  | arol S                   |                       | City or Town, Sta  | te, Zip Code)         | -                            |  |  |
| MD d 2 sho<br>Ith and<br>n 27 is   |   | Katherine Dawson, Sister   1608 South Rolling Road Halethorpe, M  |                      |                                  |                                      |                                     |   |                                  |                          |                       |  | ,                     |                              |  |  |
|  |   | 20a. Method of Disposition  1 Burial 2 X Cremation                | n 3 🗌 F              | Removal fro                      | om State                             | Place of Dispos<br>crematory or otl | ition (Name of cen<br>ner place)            |                                  | Date                     | 20c.                  | Location - City  | or Town, State        | 9                            |  |  |
| Baltimore,<br>permit. Pages I an<br>Department of Hee<br>Important: If ite   |   | 4 Donation 5 Other S<br>21. Signature of Funeral Service          |                      |                                  |                                      |                                     | natory In                                   |                                  | /08/12                   |                       | altimor  | <u> </u>              | yland                        |  |  |
| Bal<br>permi<br>Depa<br>Impo   |   | 21. Signature of 1 diversal service                               | H                    | Thoma                            | as Grego                             | or Egg                              | lame and Address<br>emation (9<br>Freder)   | Society<br>ick Roa               | Of Ma<br>d Bal           | rylan<br>timor        | d, Inc.<br>e, MD 2   | 1228                  |                              |  |  |
| Physician<br>  |   | 23a. Part I. Enter the disease, or failure. List only one cause   |                      |                                  |                                      | . Do not enter ti                   | ne mode of dying,                           | such as cardia                   | c or respirator          | y arrest, sh          | ock, or heart  | Approxin              | nate Interval<br>n Onset and |  |  |
| Examiner   | Ì   | Immediate Cause (Final disease or condition resulting in death)   |                      | one and                          |                                      | one Into                            | xicatio                                     | on                               |                          |                       | 1 '  | Death                 |                              |  |  |
|  |   | Sequentially list conditions,                                     | b                    | 10 (01 43 4                      | consequence o                        | .,.                                 |   |                                  |                          |                       |  |                       |                              |  |  |
|  | caminer   | if any, leading to immediate cause. Enter Underlying Cause        |                      | Due to (or as a consequence of): |                                      |                                     |   |                                  |                          |                       |  |                       |                              |  |  |
| 26 B E   |   | (Disease or injury that initiated events resulting in death) Last | Due d.               | to (or as a                      | consequence o                        | f):                                 |   |                                  |                          |                       |  |                       |                              |  |  |
| executed an and al - transit   | edical E  | 24 UNPENDED   | 23a,pt.]             | me.g92                           | 7 5-11                               | -12 s                               | m   |                                  |                          |                       |  |                       |                              |  |  |
| Box 68760, the death certificate be execute the attending physician and red for use as the burial - franced for use as the formula - franced for  | Med   | IF FEMALE:  | 23                   |                                  | outcome of preg                      |                                     |   |                                  |                          |                       | 3d. Date of delive   | ery                   |                              |  |  |
| Box 68760,<br>e death certificate be<br>the attending physical<br>for use as the but   | cian  | 23b. Was decedent pregnant in t past 12 months?                   | ne   1               | Live bi                          | irth<br>ant at time of de            | ath - H                             | taldeath 3 [<br>her <i>(Specify)</i>        | Ectopic preg                     | gnancy                   |                       | Month  | Day                   | Year                         |  |  |
| BOX<br>e death<br>the atte   | Physician/M   | 1 Yes 2 No 9 Un   |                      |                                  |                                      |                                     | N   |                                  |                          |                       |  |                       |                              |  |  |
| P.O. es that th igned by   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobu |   |                      |                                  |                                      |                                     |   |                                  |                          | _                     | pacco use contribute to the cause of death?  2 No 3 Probably 4 ✔ Unknown |                       |                              |  |  |
| ds,<br>equires<br>een sig  | ated  | Cocaine Use   |                      |                                  |                                      |                                     |   |                                  | - 🗀                      | Vas an                |  | autopsy findin        |                              |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the understanding to the property of the part II. Other significant conditions contributing to death but not resulting in the understanding to the property of the part II. Other significant conditions contributing to death but not resulting in the understanding to the part II. Other significant conditions contributing to death but not resulting in the understanding the part II. Other significant conditions contributing to death but not resulting in the understanding the part II. Other significant conditions contributing to death but not resulting in the understanding the part II. Other significant conditions contributing to death but not resulting in the understanding the part II. Other significant conditions contributing to death but not resulting in the understanding the part II. Other significant conditions contributing to death but not resulting in the understanding the part II. Other significant conditions contributing to death but not resulting in the understanding the part II. Other significant conditions contributing to death but not resulting in the understanding the part II. Other significant conditions contributing to death but not resulting in the understanding the part II. Other significant conditions contributing to death but not resulting in the understanding the part II. Other significant conditions contributing to death but not resulting in the understanding the part II. Other significant conditions contributing to death but not resulting the part II. Other significant conditions contributing the part II. Other significant conditions con |   |   |                      |                                  |                                      |                                     |   |                                  | _  r                     | utopsy<br>erformed?   | death  |                       |                              |  |  |
| al Renor The   | Beco  | 25. Was case referred to medica                                   | 1                    |                                  |                                      |                                     | 26.Place                                    | of Death (Che                    |                          | res 21                | No 1 🗸   | res 2                 | ∐ No                         |  |  |
| F Vita   | 일   | examiner?  1 ✓ Yes 2 No   | Hospi                | " "                              |                                      | ER/Outpatient                       |   | Other   Nur                      |                          |                       |  | er:                   |                              |  |  |
| on of \alpha oding Phy hi.  The After the funeral of the odine of the odine od | .i.   | 27. Manner of Death  1 Natural 5 Pen                              | - 1                  |                                  | Day, Year)                           | 28b. Time of I                      |   | y at Work?<br>'es 2 🛣 No         | unkno                    |                       | jury occurred  |                       |                              |  |  |
| Division<br>tal or Attendi<br>rs after death.  | ficat   |   | stigation            |                                  | -5-12<br>of Injury - At he           | fd 5:40<br>ome, farm, stree         | ot, factory, office be                      |                                  |                          |                       | and Number or f  |                       |                              |  |  |
| Div<br>pital o   | Certification   | 4 Homicide dete   | rmined               | (Specify)                        | foun                                 | d in ho                             | use   |                                  | Halet                    | wn, State) 9<br>horpe | 19 Impe  | rial C                | t.                           |  |  |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physiciae: The law requires that the death certificate be executed within 24 hours after death. To the Fuceral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi  | ledical (   | 29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa      | hysician: 'miner:On' | To the best<br>the basis o       | t of my knowleds<br>of examination a | ge, death occur<br>nd/or investigat | red at the time, da                         | te and place, a                  | nd due to the            | cause(s) a            | nd manner as st<br>ace, and due to                                       | ated.<br>the cause(s) |                              |  |  |
| To 1   | Med   | 29b. Signature and title of certific                              | and                  | manner st                        | tated.                               |                                     | 29c. License                                |                                  |                          |                       | Date signed (N   |                       | ar)                          |  |  |
|  |   | Pat 1   | _                    | Rol                              | 01.                                  |                                     | O.C.M                                       | И.E.                             |                          | Ma                    | y 6, 2012  |                       |                              |  |  |
| -  |   | 30. Name and address of persor                                    | who comp             | leted caus                       | e of death (Item                     | 23a)                                |   |                                  |                          |                       |  |                       |                              |  |  |

State

Registrar OCME 2006

Patricia Aronica-Pollak MD.

UUNE

ORIGINAL

32. Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 1 tem 20 per ft 9927 5-24-12 lytt and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Year Aro Navarini Mav Medical 11:12 a 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death  $N/\ell$ 3918 Colborne Road <u>Baltimore</u> 6. Sex 8. Date of Birth (Month, Day, Year) November 12,1921 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Days Un Country) Director 90 234-26-0062 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Funeral Director M/A28a-f Maryland Baltimore 1XX Yes 2 No 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? 3918 Colborne Road 21229 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Examiner ò Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 NNo Specify. "natural", 3 Widowed 4 X Divorced Specify: White Year or Dates Anity the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Car Assembly General Motors other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I မ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sł Department of Health a Important: If item 27 is any injury or other trai once. 5500 Lexington Road, Apt. 108, Baltimore, Maryland 21207 Towanda Taylor / Executor 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 5/<del>15/</del>12 1)XX Burial 2 Cremation 3 Removal from State Mary Tand Veteran's Cenetery Garrison Forest, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ucensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of physician and s the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p as IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day the 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ANEMIA Records, No 3 Probably 4 Unknown Completed 1 🗌 Yes MYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 24a. Was an nas autopsy performe Yes 2 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 28d. Describe how injury occurred Natural Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Pwithin 24 only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Pript) VIN ESA Date filed (Month, Day, Year)
MAY 1 0 2012 . Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                     |   |                  | 1 - For<br>State<br>Registrar  | State of Maryl  |   | artment of H  |   | Mental Hy                       | ygiene<br>Reg. No. 20                    | 12 148  | 83                |
|---------------------|---|------------------|--|---|---|---|---|---------------------------------|--|---|-------------------|
|                     | Physicia<br>Media   |                  | 1. Decedent's Name (First, Middle, Last)  Margaret S. Owen   | t .   |   |   |   | 2. Date of Day<br>Month<br>May  | _  | 3. Time of Dea<br>5:00  | ath<br><b>A</b> M |
|                     | Examir  | ner              | 4a. Facility Name (if not institution, give str.  Vantage House  5. Social Security Number 6. Sex  |   | uro loot birthdo.                           | 4b. City, Town, or  Co  | Location of Death  lumbia  If Under 24 Hrs. |                                 |  | Howard  |                   |
|                     | Funeral<br>Director<br>words table  |                  |  | M 2 X F 91  | Yrs. last birthday)  Yrs.  City, Town or Lo | Months Days   | Hours Min.                                  | 8. Date of Bi<br>(Month, D      | 28, 1920                                 | 9. Birthplace (State or For Country)  Maryland  10d. Inside City Lir                            |                   |
|                     | a or 28a-<br>be notifie   | Funeral Director | Maryland Howar  10e. Street and Number   |   |   | 10f. Zip Code   | umbia                                       |                                 | 10g. Citizen of Wh                       |   | J No              |
| 36                  | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  | þ                | 1 Never Married 2 Married  | 2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give |   | Was Decedent of His<br>f Yes, specify Cubar                       |   | ecify Yes or No<br>Rican, etc.) | United  14. Race Black, Specify:         | d States  - American Indian, , White, etc.  White   |                   |
| 21215-0036          | vithin 72 hours<br>lene.<br>rr than "natura<br>the Medical E  | Completed        | 3 🕅 Widowed 4 □ Divorced  15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)  | Year or Dates.<br>ation   | 16a. Deced                                  | dent's Usual Occupa<br>kind of work done do<br>O NOT use retired) | ation                                       | ding                            | 16b. Kind of Bus                         |   |                   |
|                     | should be filed within 72 h and Mental Hygiene. 7 is marked other than "raumatic event, the Mec   | To Be            | 17. Father's Name (First, Middle, Last) <b>Hiram Snead</b>   | <b>-</b>  | į Ludvo.                                    |   | _   | ne (First, Middle<br>Rouzer     | , Maiden Surname)                        |   |                   |
|                     | and 2 should tealth and sem 27 is mother traumants.   |                  | 19a. Informant's Name/Relationship (Type,  John Owen / Son  20a. Method of Disposition   |   | 4612 1                                      | Morningwo   |   |                                 | er, City or Town, Sta<br>, Marylan       | nd 20832  |                   |
| altimor             | permit. Page 1 and 2: Department of Health Important; If item 27 any injury or other tr   |                  | Burial 2    Cremation 3    Re     Donation 5    Other (Specify)  21. Signature of Funeral Service Licensee   | moval from State  | etro Cre                                    | matory or other place   | nc. 05/09                                   | 9/2012<br>mation                | Baltimor                                 | ce, Maryland of Maryland  | Inc               |
| ğ                   | permit<br>Depar<br>Impor<br>any in  |                  | 23a. Part 1. Enter the disease, or complicion shock, or heart failure. List only one of  | ations that caused the d  | 29  | 9 Frederi   | ick Road,                                   | Baltin                          | nore, Mar                                | yland 21228 Approximate   | - 8               |
|                     | Physician/<br>Medical<br>Examiner   |                  | Immediate Cause (Final disease or condition resulting in death)  |   | Cancer<br>Sequence of):                     |   |   |                                 |  | Interval Between<br>Onset and Death   |                   |
| D.                  | ate be executed physician and the burial-transit  | dical Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a cons  |   |   | -   |                                 |  |   |                   |
| Baltimore, Maryland | death certific<br>ne attending  <br>ed for use as   | /Me              | JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown   | If yes, outcome of pre  | Fetal death 3                               | Ectopic pregnancy Other (specify)                                 | ,   |                                 | 23d. Date<br>Montl                       | ,   |                   |
|                     | quires that the series of signed by the details of | by               | Part II. Other significant conditions contri   | buting to death but not   | en in Part I.                               |   | ute to the cause of death?                  |                                 |  |   |                   |
| Recor               | : The law rec<br>cate has bec<br>; page 2 sho   | Completed        |  |   |   |   |   |                                 | psy prie<br>ormed? de:                   | ere autopsy findings availal<br>or to completion of cause<br>ath?<br>Yes 2 \( \sum \text{No} \) |                   |
| ital                | iician: The<br>certificate<br>rector, pag   | (m)              | 25. Was case referred to medical examiner?   | pital:  |   | Othor   | ce of Death (Check                          | k only one)                     |  |   |                   |
| on of V             | In the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director,   | icate: To        | 1  Yes 2  No Pros  27. Manner of Death  1  Natural 5  Pending 2  Accident Investigation  | 1 ☐ Inpatient 2<br>28a. Date of injury<br>(Month, Day, Year)      | 28b. Time of                                | 28c. Injury work?   | 4 X Nursing Ho<br>at                        |                                 | dence 6 Other (                          | Specify)  |                   |
| Division            | Hospital or Attending<br>24 hours after death.<br>Funeral Director: After<br>stely filled in by the funer   | al Certificate:  | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined   |   | 28f. Location (S<br>City or Tov             |   | or Rural Route Number,                      |                                 |  |   |                   |
|                     | To the Hospital within 24 hours To the Funeral completely filled  | Medical          | 29a. Certifier (Check 2 Medical Examiner: only one) 3 Certifying Nurse P   | On the basis of examina   | ation and/or investi                        | gation, in my opinion<br>death occurred at the                    | , death occurred at<br>e time, date and pla | the time, date a                | and place, and due to                    | the cause(s) and manner s   | stated.           |
| •                   | Cor.  |                  | 29b. Signature and title of certifier  | mr  | >   | 29c. License i  |   |                                 | 29d. Date signed (*) <b>May 8, 2</b> (*) |   |                   |
|                     | <b>Y</b>  |                  | 30. Name and address of person who come Dr. Andrew Lazris,   | -   |   |   | bia, Mar                                    | yland 2                         | 21044                                    |   |                   |
|                     | Stat<br>Registra  | ٠                | 31. Date filed (Month, Day, Year)  | 32. Registrar's Sig   | nature                                      |   |   |                                 |  |   |                   |

DHMH 17 Rev 06-2011

Division of Vital Records, P.O. Box 68760 6.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Care Towson Baltimore Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days Hours **Director** 219-10-9139 86 1 🛛 M 2 🗆 F Nov3,1925 Maryland show 10a. State ir then "natural", or items 23e or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 TyrYes 2 No Md Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2910 Dillon Street 21224 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 8th Factory Worker Crown. Cork & Seal Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk) should be file and Mental F ပ္ Karo1 Owsianiecki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1807 Snyder Avenue Baltimore, Md. 21222 permit. Pege 1 and 2 sh Department of Heath ar Important: If item 27 Is eny Injury or other trau Paul M. Owsianiecki/ son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. StanislausCem May Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11,2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Ligensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 201 <u>Dundalk Avenue Baltimore, Md.21222</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ METASTATIC LOARS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Day to for as a consequency off Exami Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending physical for use as the b IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Day signed by the a Id be detached f 1 ☐ Yes ∠ L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PR TENSIA After this certificate has been significate has been significated director, page 2 should I 1 Yes 2 No 3 Probably 4 X Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2x☐ No 25. Was case referred to ledical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPI ၉ To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2359 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7. Age (In yrs. last birthday) City Balk more tookin 6. Sex Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth Funeral 9. Birthplace (State or Foreign 219-64-8735 (Month, Day, Year) May 10, 1954 Months Hours 1 🗆 M 2 🖔 F Director 57 Maryland Usual Residence of Dece show 10a. State 10b. County filed within 72 hours after death with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director be notified 28a-f Md. Baltimore City 1X Yes 2 ☐ No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 818 South Milton Avenue 21224-3735 U.S.A. Examiner must 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No "natural", or ģ 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White Completed 3 Divorced 4 Divorced Year or Dates than "natura the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha event, the Home Maker Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mary J. Groves and Mental F t. Page 1 and 2 should be file tment of Health and Mental P rtant: If item 27 is marked o John H. Henson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Pearsall/Husband818 South Milton Avenue Baltimore,Md.21224 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. State Department of H Important: If ite any injury or oth once.  $May^{Date}$ 1 Burial 2 Peremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 9, 2012 Baltimore, Maryland Signature Funeral Sovice Licensee 22. Name and Address of Facili Kaczorowski Funeral Home, PA M00933 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ therpscleronc disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence or): Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Month Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Tes 2 No 3 Probably 4 Y Unknown 24b. Were autopsy findings available 24a. Was an has autopsy performe prior to completion of cause of death? 1 Yes Yes 2 🔀 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ျာ 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending ours after death. leral Director: Af filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier

State
Registrar

M DHMH 17 Rev 06-2011

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month James 10:30 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Nursing Parkville romwell If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. April 1971 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 1 M M 2 □ F 7. Age (In yrs. last birthday) **Funeral** 457-46-6157 81 Yrs. Director Texas Usual Residence of Decedent permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore MD 1 🗆 Yes 2 🛣 No 10f. Zip Code 21220 10e. Street and Number 10g. Citizen of What Country? Funeral 6905 Harewood Park Drive 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. White þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Worker GM Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Tilly Reed Edgar Reed 19a. Informant's Name/Relationship (Type, Print) Wanda Reed/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 6905~Harewood~Park~Dr.~Baltimore, MD. 20b. Place of Disposition (Name of Hotely, cremetery, or other place) 20a. Method of Disposition 20c. Location - City or Town, State 05/18/12 1XXBurial 2 Cremation 3 Removal from State Baltimore, 4 ☐ Dopation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Funeral Servi Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine rany, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner? Other: 2 No ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1. Natural 5 Pending 2 🗆 No Investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (SpecIfy) 28f. Location (Street and Number or Rural Route Number, filled in by determined 24 hours a Medical 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

M.D

32. Registrar's Signature

8710

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUNG

PAMEL

31. Date filed (Month, Day, Year)

D006845

EMGE RD.

PARVILLE

05,08,2012

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend items 9,15-22 per fh g927 5-14-12 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Valerie Reda 7:40 AM 2012 Medical 00) Examiner 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Genesis Multimedica Baltimore LOWSON Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar 18, 1941 9. Birthplace (State or Foreign Country) CA. unk **Funeral** 1 M 2 T Months Days Hours Min 551-54-6613 **Director** 71 Mar Usual Residence of Decedent 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 √ Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 301 McMechen Street #412 21217 USA hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white Completed 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. unk unk (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Freelance Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk 2 Robert Lyons Amelia <sup>19a. In</sup>freddie Redd/Husband <del>Multi Medical Center</del> 19b. Man Amen Creman NS ter or Apat Rout (Alumber, City or Town, State, Zip Code) 7700 York Road Towson, MD 21204 Balto. Md. 21286 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other placel 4 Donation 5 W Oth in state 5-1-2012 Chesapeake Crem. Beltsville, Md. Sign cure of Funeral Service Ron III CAFA/StephenyD. Lohrman PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final End Stage Chronic Obstructive Pulmonary Disease Physician/ disease or condition resulting in death) vears Medical Due to (or as consequence of) Examiner (1 pack pears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed the burial-tran and Due to (or as a consequence of): ed by the attending physician detached for use as the buría Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Dav Year 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Anoxic Encephalopathy Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown page 2 should Alcoholic Cirrhosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Anviety Disorder 25. Was case referred to medical After this certificate 1 Yes 2 No Yes 2 No director, Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral dir 28c. Injury at work? Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number michelle E. Kalendek CRNP R097104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WP Genesis Multimedical Center 7700 York Road Towson, MD 21204 Michelle E. Kalendek

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

31. Date filed (Month, Day, Year)

M

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|   | 1103           | enthal 1- For State Registrar                                      | State                   | e of Maryland /                             |             | rtment of<br><i>tificate of</i>   |                          | and       | Menta                              | al Hyg      |                   | Reg. Ne  | . 21                      | 0 1                                  | 2          | 1488                        |  |
|---|----------------|--|-------------------------|---|-------------|---|--------------------------|-----------|------------------------------------|-------------|-------------------|--|---------------------------|--------------------------------------|------------|-----------------------------|--|
| Physici   |                | 1. Decedent's Name   | (First, Middle,La       | ast)  |             |   |                          |           |                                    | 2           | . Date of De      | ath  |                           |                                      | 3. Time o  |                             |  |
| ledical Exam  | iner           | RODERI   |                         | С   | ROSI        | ENTHAL  |                          |           |                                    |             | Month<br>May 5, 2 | 012  | Year                      | 1                                    | 1148       | hrs                         |  |
|   |                | 4a. Facility Name (if r<br>Frederick Me                            |                         | ive street and number)<br>pital             |             | 4   | b. City, Tow<br>Frederic |           | cation of [                        | Death       |                   | ľ  | c. County of<br>Frederick |                                      |            |                             |  |
| Funeral   |                | 5. Social Security Nu  | mber 6. S               | Sex 7. Age                                  | (In yrs. la | st birthday)  | If Under 1               |           | If Under 2                         |             | 8. Date of E      | Birth (Mi  | A/DD/YYYY)                |                                      |            | ate or                      |  |
| Director  |                | 051-38-97  | 757 1                   | X M 2 F                                     |             | 66 Yrs.   | Months                   | Days      | Hours                              | Min.        | 08/1              | 6/19   | 945                       | Foreig<br>Cou                        |            | JY                          |  |
|   | l              | Usual Residence of D   |                         |   |             |   |                          |           |                                    | 1           | 00/1              | 0/ 1.  | , 13                      |                                      |            | -                           |  |
| 7 200   |                | 10a. State   | 0b. County              |   | 10c. City,  | Town or Location  | on                       |           | ·                                  |             |                   |  |                           |                                      |            | de City Limits              |  |
| and show  | ا<br>ا         | WA   | KING                    |   | SEA         | ATTLE   |                          |           |                                    |             |                   |  |                           |                                      | 1Y         | s 2 X No                    |  |
| Maryland<br>28a-f show<br>d at once.  | Director       | 10e. Street and Number 10f. Zip Code 10g. Citizen of Wh            |                         |   |             |   |                          |           |                                    | at Coun     | itry?             |  |                           |                                      |            |                             |  |
| the h   | οį             | 120 NE 52ND STREET 98105   |                         |   |             |   |                          |           |                                    |             |                   | USA  | A                         |                                      |            |                             |  |
| n with  | Funeral        | 11. Marital Status   | [77]                    | 12. Was Decedent I                          | er in U.S   | 3. Was  | Decedent of              | f Hispar  | nic Origin                         | ? (Spec     | ify Yes or N      | lo-  | 14. Race -                |                                      |            |                             |  |
| death<br>nr ite<br>must   | Ë              | 1 Never Married  | 1 2 🔼 Marrie            | 1 Yes 2                                     | X No        |   | s, specify C             |           | iexican, Pi                        | uerto Ri    | can, etc.)        |  | White,                    | etc.                                 |            |                             |  |
| after incr  | by             | 3 Widowed  |                         | d If Yes, Give Year<br>or Dates:            |             |   | Yes 2X                   |           | specify:                           |             |                   |  | Specify: [                | LIH                                  | E          |                             |  |
| hours<br>natu   | ed             |  |                         | only highest grade comp                     |             | 16a, Decedent's<br>during mos   | st of working            | life. Do  | O NOT use                          | e retired   | k done            | 16b.   | Kind of Bus               | iness/ <b>I</b> r                    | ndustry    |                             |  |
| 36<br>in 72<br>han "  | plet           | Elementary/Second  |                         |   |             | during most of working life. DO NOT use re VETERINARY RADIATIO ONCOLOGIST |                          |           |                                    |             | •                 |  | **********                | EDTI                                 | 17 A 73 77 |                             |  |
| with with Per t   | Completed      | 17 Eather's Name (E  | iret Middle Lac         | 5+  |             | UNCOL   | 10GTST                   |           | Mothor's A                         | Jama /F     | imt Middle        | Maida  |                           | EKTI                                 | NARY       |                             |  |
| filed Hy  | Be C           | 17. Father's Name (First, Middle, Last)  SAMUEL ROSENTHAL          |                         |   |             |   |                          |           | 18.Mother's Name (First, Middle, M |             |                   |  |                           |                                      | 0.64.37    |                             |  |
| 212<br>ald be<br>Ment<br>mark   | To B           | SAMUEL<br>19a. Informant's Nam                                     | e/Relationship (        | Type, Print )                               | 7           |   |                          |           | TESS]                              |             | al Route Nu       | ımber (  |                           | WITTMAN<br>or Town, State, Zip Code) |            |                             |  |
| AD 2 sho 2 sho mati   |                |  | ROSENTHAL / WIFE        |   |             | T .   |                          |           | 52ND STREET, S                     |             |                   |  |                           |                                      | <b></b>    | •                           |  |
| imore, MD 21215-0036 ment ogst 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked ather than "natural", ar items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.                                   |                | 20a. Method of Dispo   | sition                  | ·   |             | ace of Dispositi  | ion (Name o              |           |                                    |             | ate               |  | Location - (              |                                      | Fown, Stat | e                           |  |
| O D D D D D D D D D D D D D D D D D D D   |                |  | _                       | X Removal from Stat                         | e cr        | ematory or othe   |                          |           |                                    |             | 0 / 0 0 1         |  | DII                       |                                      |            | -                           |  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked atther than "natural", ar items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.        |                | 4 Donation 5 21. Sono ure of Fune                                  | Other Specifical Series | /:<br>                                      |             | FOREST  | me and Add               |           |                                    |             | 8/201             | _  |                           |                                      | O, NY      |                             |  |
| Ba Perm Department in injury  |                | MINIM  | 11/18/                  | MARI.                                       |             | - 1   |                          |           |                                    |             |                   |  | & BRC<br>KESVIL           |                                      |            |                             |  |
| Physician   |                | 23a. Part I. Enter the   | disease, or com         | plications that caused the                  | ne death. [ | Do not enter the  | mode of dy               | ing, suc  | ch as card                         | iac or re   | spiratory ar      | rest, sh   | ock, or hear              | t t                                  |            | nate Interval               |  |
| /Medical<br>Examiner  |                | failure. List only<br>Immediate Cause (Fir                         | nal disease a           | Atherosclerotic C                           |             |   | ase                      |           |                                    |             |                   |  |                           |                                      |            | n Onset and<br>Death        |  |
|   |                | or condition resulting in death)  Due to (or as a consequence of): |                         |   |             |   |                          |           |                                    |             |                   |  |                           |                                      |            |                             |  |
|   | 9              | Sequentially list cond if any, leading to imm                      |                         | Due to (or as a consec                      | uence of):  |   |                          |           |                                    |             |                   |  |                           | _                                    |            |                             |  |
|   | 틭              | cause. Enter Underly<br>(Disease or injury that                    | ring Cause              |   |             |   |                          |           |                                    |             |                   |  |                           | -                                    |            |                             |  |
| sit od  | Examiner       | events resulting in de   | eath) Last              | Due to (or as a consec                      | uence of):  |   |                          |           |                                    |             |                   |  |                           | i                                    |            |                             |  |
| O,  be executed  rician and  burial - transit   | dical          | UNPENDED   |                         |   |             |   |                          |           |                                    |             |                   |  |                           |                                      |            |                             |  |
| O,<br>e be e<br>siciau<br>burial  |                | -1-0-67  |                         | AMENDED                                     |             |   |                          |           |                                    |             |                   |  |                           |                                      |            |                             |  |
| Box 68760  • death certificate be attending physical or use as the but  | Physician/M    | IF FEMALE:<br>23b. Was decedent pre                                | egnant in the           | 23c. If yes, outcome                        | of pregna   |   | I death                  | 3 🗆 8     | Ectopic pre                        | eonancy     | ,                 | 23   | d. Date of do             | elivery<br>Da                        | av.        | Year                        |  |
| h cert<br>tendir<br>use a   | <u>5</u>       | past 12 months?  |                         | 4 Pregnant at ti                            | me of deat  | h   | r (Specify)              | <u> </u>  | Lotopio pi                         | ogi ici ioj |                   | 1  | WOTH!                     | D.                                   | ay .       | icai                        |  |
| Bo<br>e deat<br>the at  | nys            | 1 Yes 2 No   | 9 Unknow                | 9 Unknown                                   |             |   |                          |           |                                    |             |                   |  |                           |                                      |            |                             |  |
| o. that the detach  |                | Part II. Other signific  | ant conditions          | contributing to death I                     | out not res | ulting in the und   | derlying cau             | se giver  | n in Part I.                       |             |                   | _  | use contribu              |                                      |            | of death?                   |  |
| ires ti<br>signe  | d by           |  |                         |   |             |   |                          |           |                                    | _           | 1 Ye              | s 2  | <b>/</b> No 3 _           | Proba                                | ibly 4     | Unknown                     |  |
| ords, w requir  | Completed      |  |                         |   |             |   |                          |           |                                    |             | 24a. Was<br>auto  |  |                           |                                      |            | gs available<br>of cause of |  |
| ecc<br>he lav<br>tte ha   | 틹              |  |                         |   |             |   |                          |           |                                    | _           |                   | rmed?  | de                        | ath?<br>✔ Yes                        | •          | No                          |  |
| Vital Rec<br>ysicion: The<br>his certificate<br>director, page  |                | 25. Was case referred  | to medical              |   |             |   | 26.P                     | lace of [ | Death (Ch                          | eck only    |                   |  |                           | , 00                                 |            |                             |  |
| Vita  | To Be          | examiner?<br>1 ✓ Yes 2   | ¬№                      | Hospital: 1 Inpatient                       | 2 🗸 E       | R/Outpatient  | 3 DOA                    | Oth       | er <sub>4</sub> No                 | ursing H    | ome 5             | Reside   | ence 6                    | Other:                               |            |                             |  |
| Division of Vital Records, P.O. ral or Attending Physician: The law requires that the star death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach   |                | 27. Manner of Death  |                         | 28a. Date of Injury<br>(Month, Day,Yaa      | 2           | 28b. Time of Inju   | ıгу 28c.                 | Injury at | t Work?                            | 28          | d. Describe       | how inj  | ury occurred              | 1                                    |            |                             |  |
| eath.   | 텵              |  | 5 Pending               |   | ''          |   | 1[                       | Yes       | 2 No                               |             |                   |  |                           |                                      |            |                             |  |
| ivisi<br>lor Att<br>after de<br>Direct  | Įį.            | 2 Accident 3 Suicide 6   | Investigat Could not    | 28e Place of Inju                           | y - At hom  | ne, farm, street,   | factory, offi            | ce buildi | ing, etc.                          | 28          |                   | ocation (Street and Number or Rural Route Number, City |                           |                                      |            |                             |  |
| Dital ours at Illed   | Certification: | 4 Homicide   | determine               |   |             |   |                          |           |                                    |             | or Town, \$       | State)   |                           |                                      |            |                             |  |
| Division of Vital Records, P.O. Box 68760 the Hopital or Attending Physician: The law requires that the death certificate him 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physiplietly filled in by the funeral director, page 2 should be detached for use as the b |                |  |                         | ian: To the best of my I                    |             |   |                          |           |                                    |             |                   |  |                           |                                      |            | -                           |  |
| Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After I completely filled in by the funeral   | Medical        |  | edical Examine          | On the basis of exami<br>and manner stated. | nation and  | /or investigation   | n, in my opi             | nion, dea | ath occurr                         | ed at the   | e time, date      | and pla  | ace, and due              | to the                               | cause(s)   |                             |  |
| 6 1 2 1   | ž              | 29b. Signature and titl  | e of certifier          |   |             |   | 29c. Lic                 | ense nu   | umber                              |             |                   | 29d.   | Date signed               | (Mont                                | h, Day,Ye  | ar)                         |  |
|   | - 1            | 0-2  | 1                       | •   |             |   | 0.                       | C.M.E     | Ξ.                                 |             |                   | Ma   | 6, 2012                   |                                      |            |                             |  |
|   | - 1            |  | -                       |   |             |   |                          |           |                                    |             |                   |  |                           |                                      |            |                             |  |
|   | -              | 30. Name and address   | s of person who         | completed cause of dea                      | th (Item 2  | 3a)   |                          |           |                                    |             |                   | 1-   |                           |                                      |            |                             |  |
|   | -              | 30. Name and address Donna M. Vine                                 |                         | completed cause of dea<br>Assistant Medica  | •           | •   | /. Baltim                | ore Sti   | reet, Ba                           | ıltimor     | e, MD 21          | 223  |                           |                                      |            |                             |  |
| St.<br>Regist   | ate            | Donna M. Vine  | centi, MD               | Assistant Medica                            | l Exami     | ner 900 W   | V. Baltim                | ore Sti   | reet, Ba                           | ltimor      | e, MD 21          | 223  |                           |                                      |            |                             |  |

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #195 Per FH G927 5/17/2012 IH State of Maryland Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Margaret R. Stierstorfer 2012 May 5:08 РМ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 410 Amy Drive Harford Abingdon Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 209-18-8871 **Director** 1 □ M 2 🂢 F Dec 28, 1927 84 Pennsylvania Usual Residence of Decedent 28a-f show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho must be notified at 10c. City, Town or Location Director 1 🗆 Yes 2 😾 No Maryland Harford Abingdon 10e. Street and Number 10g. Citizen of What Country? Funeral 410 Amy Drive 21009 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore County School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Velma Schmidt Russel Kishbauch 198 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health a item 27 is Beth OBrennan, Daughter Cimarron Circle Parkville, Maryland 21234 20a. Method of Disposition permit. Page 1 an Department of H Important; If iten any injury or oth once. 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, Metro Crematory Inc. 05/10/12 4 Donation 5 Other (Specify) Baltimore, Maryland Thomas 22. Name and Address of Facility. Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Signature of Funeral Service Licensee Gregor 23a. Part 1. Enter the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical sequence of): Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): ysician and ie burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 No Hospital or Attending Physician: 24 hours after death. Division of Vital filled in by the funeral director. Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Hospita 2 No Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident 24 hours after death Funeral Director: Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 05.09.17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahmood Alikhan, MD 7505 Osler Drive Towson, MD 21204 State MAY 1 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14891 For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ a:43p HNN Deborah 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Washington Hagerestown Julia Manor Healthco 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month Min (Month, Day, Year, Country) Director 218-62-7775 1 M 2 X F Aug 16, 1954 Maryland 57 28a-f show 10d. Inside City Limits at 10a. State 10b. County 10c. City. Town or Location Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sl any injury or other traumatic event, the Medical Examiner must be notified is 1 X Yes 2 No Washington Hagerstown MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Numbe Funeral United States 11 W. Baltimore St. #1103 21740 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. by 1 ☐ Yes 2 🕱 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ 12 Factory Worker Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Beverly Ann Bloom Robert Paul Houser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Hopewell Rd. #D Williamsport, MD 21795 Kelli Hann / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 5/10/2012 4 Donation 5 Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service Lie Going Home Crematicn Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Stage Physician/ Liver End disease or condition Medical resulting in death) **Examiner** Encephalopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Obstructive pulmowary Disease Cause (Disease or injury that initiated events resulting in death) Last burial-tran ependent Diabetes Mellitus attending physician Physician/Medical certificate be Box 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ ò in the past 12 r Hospital or Attending Physician: The law requires that the death Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ Unknown Unknown P.O. 1 signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? þ Hepatitis C, Osteoarthritis, Hypothyroidism, 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv death? 1 Yes 2 No After this certificate ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending s after death. М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 2 R125360 CRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP-333 M:11 Street, Haverstown, MD21740 Naden-Blucher 31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KEGINALD 33 SHIELDS Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death AMARITAN HOSP ITAL BATIMORE Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 218-60-4211 Director 1 M 2 🗆 F 58 Yrs. 02-09 Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits must be notified at Funeral Director MD or 28a-f BALTIMORE 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? BURNWOOD or items 23a ROAD 21239 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Specify: BLACK Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) BALTIMORE CITY SCHOOLS Elementary/Secondary (0-12) College (1-4 or 5+) NGINEER Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ SHIELDS 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) BAUTIMORE, MD 14/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Lice see VALIGHN GREENE FUNERAL SON BATTIMORE, MO. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying. Approximate Interval Between shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that the death certificate be executed and trar that initiated events resulting in death) Last Due to (or as a consequence of) burial physician Physician/Medical Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 month 1 Yes 2 No Month Pregnant at time of death Dav 1 Yes 2 2 9 Unknown Unknown Division of Vital Records, P.O. p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 performed? Yes 2 No or: After this certificate I the funeral director, pag 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 \sum Yes 2 \sum No 1 Natural injury iours after death.

neral Director: Af

filled in by the fu Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Number Frantitioner: To the bont of my incoming active time, date and place, and one to the cause(s) and manner stated Certifying Number Frantitioner: To the bont of my incoming active time, date and place, and one to the cause(s) and manner stated Certifying Number Frantitioner: To the bont of my incoming active time, date and place, and one to the cause(s) and manner stated Certifying Number Frantitioner: To the bont of my incoming active time, date and place, and one to the cause(s) and manner stated Certifying Number Frantitioner: To the bont of my incoming active time, date and place, and due to the cause(s) and manner stated Certifying Number Frantitioner: To the bont of my incoming active time, date and place, and due to the cause(s) and manner stated Certifying Number Frantitioner: To the bont of my incoming active time, date and place and place active time. (Check 29b. Signature and title of certifier ompleted cause of death (Item 23a) (Type, Print) aver

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 14893 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Physician/ 10:40PM Mary M. Skinner MAY 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death n/a BALTIMORE AbNES HOSPITAL Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) 310-20-1215 **Director** 1 ☐ M 2 💢 F 100 Yrs. 4/24/1912 Kentucky Usual Residence of Decedent 28a-f show 10c. City. Town or Location notified at 10a State 10d. Inside City Limits Director Baltimore 1 🗌 Yes 2 🔀 No MD Lansdowne 10e. Street and Number 10f. Zip Code ь 10g. Citizen of What Country? must be Funeral items 23a 220 Fourth Avenue 21227 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Examiner Black, White, etc. 9 þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 'natural", 3 X Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Packer Retail 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked or unk မ Eli Cowan Lockie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46234 Department of Health ar Important: If item 27 is usually injury or other Carolyn Coleman / Niece 5890 Jamestown Square Lane, Indianapolis, IN Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🗆 Cremation 3 🔀 Removal from State Donation 5 Other (Specify) Clay, 5/7/2012 Oddfellows Cemetery Kentucky of Funeral Service Licens 22. Name and Address of Facility Hubbard Funeral Home, Inc. Signature 4107 Wilkens Avenue, Baltimore, Maryland 21229 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death INFECTION Ph sician/ URINARY TRACT 2 WEEKS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): death certificate be executed Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ LYMPHOPROLIFERATIVE Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? death? 1 Yes 2 No Yes 2 A No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 ANO မ 1 Department 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending work 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 10065861 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21227 2717 HAMMONDS FERRY RD AWAN 31. Date filed (Month, Day, Year, State 1 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Savvas Nicolaos Sarris 345 AM 08 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/AUnion Memorial Hospital Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** January 12, 1923 Months Davs Hours Rhodes, Greece 215-56-6975 **Director** 1 Ϊ XM 2 🗆 F 89 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A1 Yes 2 No Maryland **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 4102 Weldon Place West 21211 Jnited States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force
1 Yes 2
If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced 2**X** No 1 ☐ Yes 2 🙀 No Specify: Specify: Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Cook Eastern Avenue Resturants 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nicolaos Em Sarris Anna Anastasa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4102 Weldon Place West, Baltimore, Maryland, 21211 Irene Sarris / Wife 20a. Method of Disposition
1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Greek Orthodox Cemetery May 12,2012 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. aud Mu 3631 Falls Road, Baltimore, Maryland, 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ abdominal anevigen Ruptured disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Abdominiel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year page 2 should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has the completely filled in by the funeral director, page 2 standards. performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011

M

29b. Signature and title of contifier

31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen Ngryon, M.O. 261 East University Parkers, Bultimer Ms 21218

32. Registrar's Signature

00063163

29d. Date signed (Month, Day, Year) My 8. 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day May 2012 Par 04 3:12 pM Patricia Stevenson Byrnes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral Director** 215-34-7283 1 □ M 2 🛛 F 74 May 27, 1937 Maryland Usual Residence of Decede 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f s 1 Yes 2 No Maryland Baltimore Timonium 10 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 39 Oakway Road 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. 0 Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 🗶 No If Yes, Give 1 ☐ Yes 2 🛣 No Specify: Baltimore, Maryland 21215-003 "natural", Specify 3 Divorced 4 Divorced Year or Dates White Department of Health and Mental Hygiener Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) n/a Manager Communications Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Myles Allen Byrnes Ocie Robert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timonium, Maryland Herbert Russell Stevenson, 39 Oakway Road, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date /9/12 Gardens 1 X Burial 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify) Dulaney Valley Memorial Timonium, Maryland 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road. Timonium, MD 21093 23a. Part 1. Enter the disease, or complications that cap ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, of Interval Between Onset and Death hea failure. List only one cause or Failure Immediate ( ause (Final disease or continuon resulting in death) Physician! Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? detached for Dav Pregnant at time of death 2 the 9 Unknown 9 Unknown been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform death? 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Dopatient 2 ER/Outpatient 3 DOA ၉ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No Natural Accident 5 Pending injury Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

Registrar DHMH 17 Rev 06-2011

State

2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 30 per dvr g927 5-10-12 vt. State of Maryland / Department of Health and Mental Hygiene 14896 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month erine mi 1340 2012 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomera Kenahilitation 7. Age (In yrs. last birthday, If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) Country Director 1 M 2 V 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director notified 28a-f 1 Yes 2 No 10) 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be 23a IJSA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 0 Completed by 1 Neyer Married 2 Married Black, White, etc. 1 Yes 2 1 No 1 ☐ Yes 2 ☑ No Specify: "natural", 3 Widowed 4 Divorced Specify: Blac Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Mental Hygiene. larked other than Elementary/Secondary (0-12) College (1-4 or 5+) imen Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnan ျှ and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or broth Health other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State (Date Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) TOWE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ DISCUSE CORONARY ARTTORY Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last use as the burial-trans Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav 1 Yes 2 the Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available has page 2 autopsy performed? Yes 2 prior to completion of cause of death?

1 Yes 2 o certificate Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 PNo ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural
2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5/8/12 ( and ) uno) 00057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Dr. #206 Rockville, Md. 20850 Truong Bao

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

|  |                   | For<br>State<br>Registrar  | State of Ma   | aryland / I        | Departmer<br><i>Certificat</i>                                     | nt of Healt<br>e of Deati                                       | h and M<br>h    |   | giene 2             | 012                                 | 14897  |
|--|-------------------|--|---|--------------------|--|---|-----------------|---|---------------------|-------------------------------------|--|
| Physicia<br>Medic  |                   | Decedent's Name (First, Middle, L.  Janet  | ast)<br>M•  |                    | Sadle  | er  |                 | 2. Date of Dea<br>Month<br>May 5            | th 2012             | Year                                | 3. Time of Death 5:30  |
| Examin   |                   | 4a. Facility Name (if not institution, gi<br>1925 Rettman Lan  | · ·   |                    |  | Town, or Location   | on of Death     |   | 4c. Count           |                                     |  |
| Funeral<br>Director  | Г                 | 213-70-3813  | Sex 7. Age 1 ☐ M 2 🔀 F  | (In yrs. last birt | hday) If Unde<br>Months<br>Yrs.                                    | r 1 Year   If Und<br>Days   Hour                                |                 | 8. Date of Birtl<br>(Month, Day<br>February | (Year)              | g. Birthplace<br>Country)<br>Maryla | e (State or Foreign<br>and   |
| aryland<br>a-f show<br>fied at   | ector             | Usual Residence of Decedent  10a. State 10b. County  Maryland Baltim   | ore   | 10c. City, Town    | or Location<br>rundalk   | l l   |                 |   |                     |                                     | Inside City Limits   |
| vith the Ma<br>23a or 28<br>st be noti   | Funeral Director  | 10e. Street and Number 1925 Rettman Lan  |   |                    | 10f. Zij   | Code 212  | 222             |   | 10g. Citizen of USA | What Country?                       |  |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Mimportant: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.      |                   | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Moivorced   | 12. Was Decedent E-Armed Forces? 1 Yes 2X If Yes, Give Year or Dates.       |                    | If Yes, spe  | dent of Hispanic<br>cify Cuban, Mexi<br>2 XNo Spec              | can, Puerto     | ecify Yes or No-<br>Rican, etc.)            | Bla                 | ce - American l<br>ck, White, etc.  |  |
| ithin 72 hours<br>ene.<br>r than "natur<br>the Medical I   | Completed by      | 15. Decedent's<br>(Specify only highest<br>Elementary/Secondary (0-12)<br>12 years   | Education   | +)                 | Decedent's Usu<br>(Give kind of wo<br>life. DO NOT use<br>Commeric | rk done during m<br>retired)                                    |                 | ing   | 16b. Kind of E      | Business/Indust                     | rry  |
| ild be filed w<br>Mental Hygi<br>larked othe<br>latic event, i   | To Be             | 17. Father's Name (First, Middle, Las<br>John Burnett  | ,   |                    |  | 18. Me  | other's Name    | e (First, Middle, 1<br>herbach              |                     |                                     |  |
| nd 2 shou<br>ealth and<br><b>m 27 is m</b><br>ner traum  |                   | 19a. Informant's Name/Relationship Nicole Ruckle   | (Type, Print)  Daughter   | 20                 | . Mailing Address  | ette Roa  |                 |   |                     |                                     |  |
| Page 1 a<br>ment of H<br>tant: If ite<br>iury or oth   |                   | 20a. Method of Disposition 1 □ Burial 2 X Cremation 3 4 □ Donation 5 □ Other (Spe  |   | cemeter            | f Disposition (Narry, crematory or co.<br>ew Crematory             | ther place)   | May 9           | , 2012                                      |                     | - City or Town, ore, Ma             |  |
| permit<br>Depart<br>Import<br>any inj  |                   | 21. Signature of Funeral Service Lice  | Conned  | lles               | Conne<br>7110  | fly Fune<br>Sollers   | ral He<br>Point | ome Of I<br>Road, I                         | Dundalk<br>Dundalk  | ,P.A.<br>,Maryla                    | ınd 21222  |
| Physician/ Medical Examiner  he prival-transit   | Examiner          | 23a. Part 1. Enter the dises e r co shock, or heart failure t only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a  | consequence of     | CER<br>on:<br>bstruct<br>on:                                       |   |                 | AISCASC                                     |                     | Inti<br>On                          | proximate erval Between set and Death Set an |
| In the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bi | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown  | 23c. If yes, outcome of 1  Live Birth 2                                     | Fetal death        |  | 3 ☐ Ectopic pregnancy 23d. Date of de 5 ☐ Other (specify) Month |                 |   |                     |                                     |  |
| requires that the been signed be should be deta  | by                | Part II. Other significant conditions  | contributing to death bu  | it not resulting i | n the underlying   | cause given in Pa   | art I.          |   |                     | 3 Probabi                           | ause of death?  y 4  Unknown  findings available   |
| an; The faw<br>tificate has<br>tor, page 2   | Be Completed      | 25. Was case referred to medical   | <u> </u>  |                    |  | 26. Place of D  | Death (Check    | autop<br>perfor<br>1 🗌 Yes                  | sy<br>med?          |                                     | etion of cause of  |
| Physici<br>r this cer<br>eral direc  | 은                 | examine 1 Ves 2 No 27. Manner of Death   | 28a. Date of injury   | y 28b. T           | itpatient 3 D  | Other: 4  8c. Injury at   |                 | me 5 Residence 128d. Describe ho            |                     |                                     |  |
| or Attending<br>fter death.<br>irector: Afte<br>in by the fun  | Certificate:      | 1  |   |                    |  |   |                 |   |                     | ite Number,                         |  |
| le Hospital i<br>n 24 hours a<br>le Funeral D<br>bletely filled i  | Medical C         | (Check 2 L Medical Exa   | nysician: To the best of miner: On the basis of exursedPractitioner: To the | amination and/o    | r investigation, in  | my opinion, death   | occurred at     | nd due to the car<br>the time, date ar      | use(s) and man      | e to the cause(s                    |  |
| Vithii<br>To th<br>comp  | _                 | 29b. Signature and title of certifier  | fley  |                    |  | License numbe   |                 |   | 29d. Date signe     |                                     |  |
| Shy  |                   | 30. Name and address of person who San Aliana (Month, Day, Year)   | MD. 6   | 730                | Type, Print)   | GIRD 1  | AUE             | Bn 1h                                       | mo                  | 2/2                                 | 22   |
| Stat   | te                | MAV 1 (1 2012)   | 32. Registrar   | a Signature        |  |   |                 |   |                     |                                     |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

14898

|                            |  | -                | For<br>State<br>Registrar   | State of Maryla  |                     | epartment<br>Se <i>rtificate</i>                       |                                     |                           |  | giene<br><sub>Reg. No</sub> |                           | _ , , , , ,  |
|----------------------------|--|------------------|---|--|---------------------|--|-------------------------------------|---------------------------|--|-----------------------------|---------------------------|--|
|                            | Physicia   |                  | Decedent's Name (First, Middle, Las  Ronald Bra   | -  |                     |  |                                     |                           | 2. Date of Dea                           |                             | 2012 <sup>Year</sup>      | 3. Time of Death 1 1:00P M                         |
|                            | Medic<br>Examin  |                  | 4a. Facility Name (if not institution, give SAINT JOSEPH M  | street and number)   | red                 |  | own, or Locat                       | tion of Death             |  | 4c.                         | . County of Deat          |  |
|                            | Funeral<br>Director  |                  | 5. Social Security Number 6. Se 090–26–6848   |  |                     | y) If Under 1  | Year If Ur<br>Days Hou              | nder 24 Hrs.<br>Irs Min.  | 8. Date of Birt<br>Month, Date<br>June 2 | th                          | Co                        | DRE thplace (State or Foreign untry) Y York        |
|                            | yland<br>f show<br>ed at   | ctor             | Usual Residence of Decedent  10a. State 10b. County   |  | City, Town or       |  | Gl                                  |                           | 1935_                                    |                             | New                       | 10d. Inside City Limits                            |
|                            | the Mar<br>a or 28a-<br>be notifi  | Funeral Director | Maryland Baltim   |  |                     | 10f. Zip (   | Code                                | sville                    |  | 10g. Cit                    | tizen of What Co          | 1 🗆 Yes 2 🛣 No                                     |
|                            | eath with<br>tems 23<br>er must  | Funera           | 15 Valley Lake Plant 11. Marital Status   | 12. Was Decedent Ever in L   | J.S. 1              | 3. Was Decede  | 2103                                | o Origin? (Spe            | cify Yes or No-                          | of                          | 14. Race - Ame            | rican Indian,                                      |
| S 888                      | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Completed by I   | 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced  | Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.                                   |                     | 1 🗌 Yes 2  | <b>X</b> No Sp∈                     | kican, Puèrto I<br>ecify: | Rican, etc.)                             |                             |                           | hite   |
| <b>S</b> 15-15-1           | hin 72 ho<br>ne.<br>than "nat<br>te Medica   | omple            | 15. Decedent's Ed<br>(Specify only highest gra<br>Elementary/Secondary (0-12)   | de completed)  College (1-4 or 5+)   | (G<br>life          | ecedent's Usual<br>ive kind of work<br>e. DO NOT use r | done during<br>retired)             | most of worki             | ng                                       | 16b. K                      | ind of Business/          | 'Industry  |
| 3,5                        | filed wit<br>al Hygie<br>d other   | Be               | 12  <br>17. Father's Name (First, Middle, Last)   | 5+   | •                   | Attorn   | -*                                  |                           | e (First, Middle,                        |                             |                           |  |
| Charyland 2                | nould be<br>nd Ment<br>s marke<br>umatic e   | 인                | Andrew Sh   |  | 19b. M              | ailing Address   | Street and Nu                       |                           | illie M                                  |                             |                           | Code) 21030  |
| e, M                       | and 2 sh<br>Health a<br>em 27 is<br>ther trau  |                  | Amelita A. Sherer   |  | 1                   | 5 Valle  | y Lake                              | Place                     | Apt. B                                   | COC                         | ckeysvil                  | le, Maryland                                       |
| Sheller Baltimore,         | t. Page 1<br>tment of 1<br>tant: If it<br>ijury or o   |                  | 1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify  | Removal from State   | Evans               | Funera<br>- Bel A                                      | ir<br>İr                            | May 20                    | 12                                       | For                         |                           | l, Maryland  |
| <u>ية</u>                  | permir<br>Depar<br>Impor<br>any in   |                  | 21. Signature of Fuheral Service Licen  | 88   |                     | 22. Name and Peacefu 23                                | Address of F<br>1 Alter<br>25 Yordk | natives<br>Road T         | Funeral<br>imonium,                      | and (<br>Mary               | Cremation<br>land 2109    | Center, P.A.                                       |
|                            | Physician/   |                  | 23a. Part 1. Enter the disease, or companions, or heart failure. List only or Immediate Cause (Final disease or condition | olications that caused the de<br>ne cause on each line.<br>METASTAT                        |                     |  | , ,                                 |                           |  | rest,                       |                           | Approximate<br>Interval Between<br>Onset and Death |
| -                          | Medical<br>Examiner  |                  | resulting in death)   | aDue to (or as a conse   | quence of):         |  |                                     |                           |  |                             |                           |  |
|                            | ed   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury               | b. Due to (or as a conse   | quence of):         |  |                                     |                           |  |                             |                           |  |
| 0                          | cate be executed<br>physician and<br>s the burial-transit  | edical Exa       | that initiated events resulting in death) Last  | Due to (or as a conse  | quence of):         |  |                                     |                           |  |                             |                           |  |
| 8760                       | tificate<br>ng phys<br>as the  | Medi             | IF FEMALE:  | d  |                     |  |                                     |                           |  |                             |                           |  |
| . Box 68                   | Attending Physician: The law requires that the death certificar death.  •ctor: After this certificate has been signed by the attending to the funeral director, page 2 should be detached for use as   | Physician/M      | 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  | 23c. If yes, outcome of pregi<br>1  Live Birth 2 Fe<br>4  Pregnant at time o<br>9  Unknown | etal death          | 3 Ectopic pr<br>5 Other (spe                           |                                     |                           |  |                             | 23d. Date of del<br>Month | livery<br>Day Year                                 |
| ls, P.O                    | uires that the dea<br>n signed by the a<br>uld be detached f   |                  | Part II. Other significant conditions of INFERIOR VENA  |  |                     |  | use given in l                      | Part I.                   |  |                             |                           | the cause of death?                                |
| Division of Vital Records, | The law require<br>ate has been si<br>page 2 should I  | Completed by     |   |  |                     |  |                                     |                           | 24a. Was<br>autor<br>perfo<br>1  Yes     | osy                         | prior to                  | topsy findings available completion of cause of    |
| /ital                      | <b>yslcian:</b> The<br>is certificate<br>director, pag   | To Be (          | 25. Was case referred to medical examiner?  1  Yes 2 XNo  | Hospital:  | FR/Outps            | atient 3 DO  | Other:                              | Death (Check              | only one)                                |                             | i ☐ Other (Spec           | (6.)   |
| on of \                    | Attending Phy<br>er death.<br>ector: After this<br>by the funeral o  | Certificate: T   | 27. Manner of Death  1  | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time           | e of 28  | c. Injury at work?                  | 2                         | 28d. Describe h                          |                             |                           | ny)  |
| ivisid                     | il or Attendil<br>after death.<br>Director: Af<br>d in by the fu   |                  | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined  | 28e. Place of Injury - At building, etc. (Spec   | home, farm,<br>ify) | street, factory,                                       | office                              |                           | 28f. Location (S<br>City or Tow          |                             |                           | ral Route Number,                                  |
| (3)                        | To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b  | Medical          | (Check 2 Medical Exami  | ician: To the best of my kno<br>ner: On the basis of examinat                              | ion and/or in       | vestigation, in m                                      | y opinion, dea                      | th occurred at            | the time, date a                         | and place                   | , and due to the          | cause(s) and manner stated.                        |
| 9                          | To the within 2 To the comple  | 2                | 29b. Signature and title of certifier   | 2nd  | >                   |  | License numb                        |                           |  | 29d. Da                     | te signed (Month          | n, Day, Year)                                      |
| 5                          |  |                  | 30. Name and address of person who c  |  |                     |  | TOWS                                | OM - MD                   | 21204                                    |                             |                           |  |
| ×                          | Stat<br>Registra   | -                | 31. Date filed (Month, Day, Year)  NAY 1 0 20   | 3 Registrar's Sign   | attre               | arkel  |                                     | ,                         | 201                                      |                             |                           |  |

|                     |  | -                | State Registrar  |                                 |  | Cer                 | tificate of                           | Death                                   |  | Reg. No.                      |                        |                                     |
|---------------------|--|------------------|--|---------------------------------|--|---------------------|---------------------------------------|---|--|-------------------------------|------------------------|-------------------------------------|
|                     | #211-1-  |                  | 1. Decedent's Name (First, Middle  |                                 |  |                     |                                       |   | 2. Date of D<br>Month                  | eath                          | Veen                   | 3. Time of Death                    |
|                     | Physicia<br>Medic  |                  | John   | Peter Vac                       | cacio                                    |                     |                                       |   | May                                    | Ol Z                          | Year<br>C/Z            | 527 A M                             |
|                     | Examin   |                  | 4a. Facility Name (if not institution  | give street and num             | ber)                                     |                     | 4b. City, Town,                       | or Location of Dea                      | ath 0                                  | 4c. Coun                      | ty of Death            |                                     |
| 4                   |  | М                | Howard County  |                                 |  |                     |                                       | olumbia                                 |  | How                           |                        |                                     |
|                     | Funeral Director   |                  | 5. Social Security Number  |                                 | 7. Age (In yrs. la:                      | st birthday)        | If Under 1 Yea  Months Days           |   |  |                               | 9. Birthp              | lace (State or Foreign<br>ry)       |
|                     |  |                  | 140-46-1722 Usual Residence of Decedent  | 1 🛛 M 2 □ F                     | 60                                       | Yrs.                |                                       |   | July 1                                 | 9, 1951                       | New                    | York                                |
|                     | and<br>show  | 5                | 10a. State 10b. County   |                                 | 10c. City                                | , Town or Loc       | ation                                 |   |  |                               | 1                      | 0d. Inside City Limits              |
|                     | Maryl<br>8a-f<br>stiffied  | rect             | Maryland Carro   | 11                              |  | Sykesv              | ille                                  |   |  |                               |                        | 1 🗆 Yes 2 🔀 No                      |
|                     | a or 2   |                  | 10e. Street and Number   |                                 | •  |                     | 10f. Zip Code                         |   |  | 10g. Citizen o                | What Coun              | try?                                |
|                     | h with   | Funeral Director | 1073 King Arth   | nur Court                       |  |                     | 21                                    | 784                                     |  | USA                           |                        |                                     |
|                     | deat<br>r item<br>ner r  |                  | 11. Marital Status   | Armed For                       | dent Ever in U.S.<br>ces?                | . 13. V             | Vas Decedent of<br>Yes, specify Cul   | Hispanic Origin? (<br>pan, Mexican, Pue | Specify Yes or No<br>erto Rican, etc.) |                               | ce - Americ            |                                     |
| Maryland 21215-0036 | after<br>al", o<br>xam   | d by             | 1 Never Married 2 Mar<br>3 Widowed 4 X Divorced                                    | If Yes, Give                    |  | 1                   | ☐ Yes 2 👿 N                           | o Specify:                              |  | Specia                        | y: 171 ·               |                                     |
| ŏ                   | nours<br>latura<br>ical E  | Completed        |  | Year or Dant's Education        | tes.                                     | 16a. Deced          | ent's Usual Occi                      | pation                                  |  | 16b. Kind of                  | Whi                    |                                     |
| 215                 | n 721<br>e.<br>an "n<br>Med  | du               | (Specify only higher<br>Elementary/Secondary (0-12)                                | st grade completed) College (1- | 4 or 5+)                                 | (Give k             |                                       | during most of w                        | orking                                 | Retai                         |                        |                                     |
| 7                   | withingiene giene the the  |                  | 12   |                                 | 5  |                     | Pharmac                               | ist                                     |  |                               |                        | n Drugs                             |
| nd                  | tal Hy<br>d oth  | To Be            | 17. Father's Name (First, Middle, L  | ast)                            |  |                     |                                       | 18. Mother's N                          | ame (First, Middle                     | e, Maiden Surnar              | ne)                    |                                     |
| Уa                  | Men<br>Men<br>narke  | ۱                | Alfred   | loseph                          | Vacc                                     | acio                |                                       | Ruth                                    | Ani                                    | ta                            | Kru                    | ieger                               |
| Jar                 | ge 1 and 2 should be filed within 72 hours after death with the Maryland<br>it of Healith and Mental Hygiene.<br>If them 27 is marked other than "natural", or items 23a or 28a-f show<br>or other traumatic event, the Medical Examiner must be notified at   | - 1              | 19a. Informant's Name/Relations  |                                 |  | 1                   | -                                     | t and Number or F                       |  |                               |                        | 'ode)                               |
| a)                  | and 2<br>Health<br>em 2:<br>ther t   |                  | Donna L. Vacca 20a, Method of Disposition  | cio/Siste                       |  |                     |                                       | ook Road                                |  | T                             |                        | 0                                   |
| סר                  | permit. Page 1 a Department of I Important: If ite any injury or of  |                  | 1 X Burial 2 Cremation   |                                 | State ce                                 | emetery, crem       | sition (Name of<br>natory or other pl |   | Date                                   | 20c. Location                 | ·                      |                                     |
| Baltimore,          | iit. Pa<br>irtme<br>irtani<br>injury   |                  | 4 Denation 5 Other (S  |                                 | Dul.                                     |                     |                                       | emorial (                               |  |                               |                        | aryland                             |
| Ba                  | permit. Page 1 and 2<br>Department of Healt<br>Important: If Item 2<br>any injury or other 2<br>once.  |                  | Bryan W. Cla   | VI IIII                         | 4  | ĺ                   | emmon F                               | ess of Facility<br>uneral H             | ome of D                               | ulaney                        | Valley                 | Inc.                                |
|                     |  |                  | 23a. Part 1. Enter the osease, or  | complications that c            |  |                     |                                       | donia Ro                                |  |                               | 0 2109                 | Approximate                         |
| F                   | h sician/  |                  | shock, or eart fulure. List of Immediate Cause (Final                              |                                 | ch li e.                                 | 1. Class            | h-ted                                 | aden                                    | CacC'A                                 | 2000                          |                        | Interval Between<br>Onset and Death |
|                     | Medical  | İ                | disease or c dition resulting in deal  |                                 | orly o                                   |                     | illaica                               | aden                                    | 564 611                                |                               |                        |                                     |
|                     | Examiner   |                  |  |                                 | V .                                      | ,                   |                                       |   |  |                               |                        |                                     |
|                     |  | iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (c                    | or as a conseque                         | ence of):           |                                       |   |  |                               |                        |                                     |
|                     | cuted<br>nd<br>ransi   | Examiner         | Cause (Disease or injury that initiated events                                     | C                               |  |                     |                                       |   |  |                               |                        |                                     |
|                     | e exe  |                  | resulting in death) Last   | Due to (                        | or as a conseque                         | ence of):           |                                       |   |  |                               |                        |                                     |
| 8760                | tificate be executed<br>ng physician and<br>as the burial-transit  | Medical          |  | d                               |  |                     |                                       |   | <del></del>                            |                               |                        |                                     |
| 687                 | £ po a l   |                  | IF FEMALE:   | 23c. If yes, outo               | come of pregnan                          | ICV                 |                                       |   |  |                               |                        |                                     |
| Вох                 | ath co   | ciar             | 23b. Was decedent pregnant in the past 12 months?                                  | 1 Live E                        | Birth 2 Fetal                            | death 3             | Ectopic pregnal<br>Other (specify)    | псу                                     |  |                               | ate of delive<br>Ionth | ry<br>Day Year                      |
| m ·                 | he de<br>y the<br>iched  | Physician/       | 1 Yes 2 No   | g 🗌 Unkn                        |  |                     | , other toposity)                     |   |  |                               |                        |                                     |
| Records, P.O.       | requires that the death cert<br>been signed by the attendir<br>should be detached for use  | by P             | Part II. Other significant condition   | ns contributing to de           | eath but not resu                        | Ilting in the u     | nderlying cause (                     | jiven in Part I.                        | 23e. Did                               | tobacco use cor               | ntribute to th         | e cause of death?                   |
| Ś.                  | uld b  | ed k             |  |                                 |  |                     |                                       |   | _ 1□                                   | Yes 2 ☐ No                    | 3 🗆 Prob               | ably 4 Unknown                      |
| Ö                   | w rec<br>is bee<br>2 sho   | Completed        |  |                                 |  |                     |                                       |   | 24a. Was                               |                               | . Were autop           | esy findings available              |
| Je J                | The la<br>ate ha   | ĕ                |  |                                 |  |                     |                                       |   | per                                    | opsy<br>ormed?<br>2 Wo        | death?                 |                                     |
| . <u>a</u>          | ian;<br>ertifica<br>ctor,  |                  | 25. Was case referred to medical examiner?   |                                 |  |                     | 26.                                   | Place of Death (Ch                      |  | 2 (2) (10)                    |                        |                                     |
| 5                   | hysic<br>his ce<br>al dire   | 흔                | 1 ☐ Yes 2 ☑ No   |                                 | npatient 2 - E                           |                     | t 3 DOA Ot                            | her:<br>4  Nursing                      | Home 5 🗆 Res                           | idence 6 🗆 Ot                 | her (Specify)          |                                     |
| Division of Vital   | ing P  | ate:             | 27. Manner of Death  1 ☑ Natural 5 ☐ Pendir  | g 28a. Date o                   | of injury<br>h, Day, Year)               | 28b. Time of injury | 28c. Inju                             | rk?                                     | 28d. Describe                          | how injury occu               | rred                   |                                     |
| 0                   | ttend<br>death<br>tor: /<br>the i  | Certificate:     | 2 Accident Investig  | gation                          |  |                     |                                       | Yes 2 No                                |  |                               |                        |                                     |
| N/S                 | after<br>after<br>Direc  | Cer              | 4 Homicide determ  |                                 | of Injury - At nor<br>ig, etc. (Specify) | ne, tarm, stre      | et, factory, office                   |   |  | (Street and Num<br>wn, State) | ber or Rural           | Route Number,                       |
|                     | To the hospital or Attending Physician: The law requires that the death cen within 24 hours after death.  To the Luneral Director. After this certificate has been signed by the attendic completely filled in by the funeral director, page 2 should be detached for use  | ledical          | 29a, Certifier 1 Certifying  | Physician: To the be            | est of my knowle                         | edge, death c       | ccurred at the tir                    | ne, date and place                      | e, and due to the                      | cause(s) and mar              | ner as state           | d.                                  |
| :                   | n 24 h   | Med              | (Check 2 Medical E   |                                 | s of examination                         | and/or invest       | gation, in my opir                    | nion, death occurre                     | d at the time, date                    | and place, and d              | ue to the cau          | se(s) and manner stated.            |
| ;<br>               | To the complete of the complet | -                | 29b. Signature and title of certifier  |                                 | 4  |                     | 29c. Licen                            | se number                               |  | 29d. Date sign                |                        |                                     |
|                     | $\circ$  |                  | <b>\</b>   | Kan                             | X W                                      | 1.0.                | 000                                   | 66515                                   |  | Ma.                           | 1 61                   | 2012                                |
|                     | 19m  |                  | 30. Name and address of person   |                                 |  |                     | <i>'</i>                              |   |  |                               |                        |                                     |
|                     |  |                  | Dr. Nishi Rawa   |                                 |  |                     | . Columb                              | ia, MD                                  | Howard C                               | County G                      | eneral                 | L Hosp <b>i</b> tal                 |
|                     | Stat<br>Registra   |                  | 31. Date filed (Month, Day, Year) <b>MAY 1 0 2012</b>                              |                                 | egistrar's Signatu                       |                     |                                       |   |  |                               |                        |                                     |

Keith Sheldon Weimer, Jr.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| 2012 | 14 | 90 |  |
|------|----|----|--|
|------|----|----|--|

|  |               | 1- For State<br>Registrar                                    |  |  | Certific         | ate of L     | Death                |                         | , ,          | Re                    | g. No.                           |                |   |
|--|---------------|--|--|--|------------------|--------------|----------------------|-------------------------|--------------|-----------------------|----------------------------------|----------------|---|
| Physici  |               | 1. Decedent's Name (First,                                   |  |  |                  |              |                      |                         | 2.           | Date of Deat<br>Month |                                  |                | 3. Time of Death                              |
| Medical Exami  | ner           | VETU1  | Sheldon                                    |  | Wei              | mer          | Jr.                  |                         |              | May 4, 201            | 12 1                             |                | 0615 hrs                                      |
|  |               | 4a. Facility Name (if not ins                                | _  |  |                  |              | City, Town, Phoenix  | or Location             | of Death     |                       | 4c. County o                     |                |   |
| Funeral  |               | 5. Social Security Number                                    | 6. Sex                                     |  | n yrs. last bir  |              | If Under 1 Ye        | ear If Unde             | er 24Hrs.    | B Date of Birt        | h(MM/DD/YYYY)                    |                |   |
| Director   |               | 219–17–8597  | 1[X] M 2                                   |  | 24               | Yrs.         |                      | ays Hours               | e Min        |                       | 9, 1987                          | Foreign        |   |
|  |               | Usual Residence of Decede                                    |  | 1.   | 24               | 115.         | l                    |                         |              | - CVGIDEL             | 9, 1007                          |                |   |
| aoy  |               | 10a. State 10b. Co   |  | 10   | c. City, Town    | or Location  | 1                    |                         |              |                       |                                  |                | 10d. Inside City Limits                       |
| nd<br>sbow   | 5             | Maryland Ba  | altimore                                   |  |                  | Dund         | alk                  |                         |              |                       |                                  |                | 1 Yes 2 No                                    |
| Maryland<br><b>28a-f sbow</b><br>d at ooce   | Director      | 10e. Street and Number                                       | _  |  |                  | 1            | 10f. Zip Code        |                         |              | 10                    | g. Citizen of Wh                 | at Coun        | try?  |
| hours after death with the Maryland<br>natural", or items 23a or 28a-f sho<br>Examiner must he ootified at ooce  |               | 8053 Stratma   | n Road                                     |  |                  |              |                      | 21222                   |              |                       | US                               | SA             |   |
| h with   | Funeral       | 11. Marital Status 1 Never Married 2                         |  | Decedent Eved Forces?                        | er in U.S.       |              | Decedent of I        |                         |              | ify Yes or No-        | 14. Race<br>White                |                | can Indian, Black,                            |
| E - 7  | Fu            |  | 11   | es 2 X                                       | No               |              |                      |                         |              | Jan, 010.             |                                  |                |   |
| 5-0036<br>led within 72 hours afte<br>dygiene.<br>other than "natural",<br>the Medical Examine   | ğ             | 3 Widowed 4 15. Decedent's Education                         | Divorced If Yes, Given or Dates:           |  | stad\   16a      |              | es 2 X N             |                         |              | r done                | Specify:<br>16b. Kind of Bus     |                |   |
| 2 hou  | eted          | Elementary/Secondary (                                       |  | ge (1-4 or 5+)                               |                  | during mos   | t of working li      | fe. DO NOT              | use retired  | )                     | 100. Killa di Bus                | 111622/11      | idustry                                       |
| D36<br>thin 7<br>than<br>than  | ם             | 12 years   |  | ,  | Cc               | nstru        | ction                | Worke                   | r            |                       | Const                            | ruc            | tion  |
| 5-0036 led within 72 tygiene. other than "   | Comple        | 17. Father's Name (First, M                                  |  |  |                  |              |                      | 18.Mother               | r's Name (Fi | irst, Middle, M       | laiden Surname)                  |                |   |
|  | Be            | Keith Sheldo   |  |  |                  |              |                      |                         |              |                       | zejeski                          |                |   |
| D 2/<br>should<br>and Me<br>7 is m.  | ပ္            | 19a. Informant's Name/Rela<br>Christine Ol                   |  | )<br>mother                                  |                  |              |                      |                         |              |                       | ber, City or Town                |                |   |
| MD and 2 sho salth and 27 is   |               | 20a. Method of Disposition                                   | =  | liother                                      | 1                |              | on (Name of c        |                         |              |                       | aryland                          |                | 014   |
| Baltimore, MD 2121<br>bernit. Pages I and 2 should be fi<br>Department of Health and Mental<br>Important: If item 27 is marked<br>nijury or other traumatic event.   |               | 1 Burial 2 Cren  | nation 3 Remov                             | al from State                                | cremat           | ory or other | place)               |                         | May          | 7 <b>,</b>            | 20c. Location -                  | -              |   |
| Lim. Pag   |               | 4 Donation 5 Oth   |  |  | Bayvie           |              | _                    |                         | 201          |                       |                                  |                | Maryland                                      |
| Baltimore, MD pernit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati   | 1             | 21 Signature of Funeral Se                                   | Certsee                                    |  |                  | CON          | ne and Addre         | ss of Facility<br>Funer | al Ho        | me Qf 1               | Dundalk,                         | P.A            | yland 21222                                   |
| Physician  |               | 23a. Part I. Enter the disease                               | e. or complications th                     | nat caused the                               | death. Do no     | ot enter the | mode of dvin         | ers P                   | oint ]       | Road, I               | Dundalk,                         | Mar            | y Land 21222 Approximate Interval             |
| /Medical   |               | failure. List only one of                                    | ause on each line.                         |  |                  |              |                      | g, 00m, 00 0            |              | opiliatory all o      | or, orroor, or rroun             | `              | Between Onset and<br>Death                    |
| Examiner   |               | Immediate Cause (Final dis<br>or condition resulting in dea  |  | as a consequ                                 | ence of):        |              |                      |                         |              | -                     |                                  |                | Bodui   |
| A  |               | Sequentially list conditions,                                | b  |  |                  |              |                      |                         |              |                       |                                  |                |   |
|  | Examiner      | if any, leading to immediate cause. Enter Underlying C       | Due to (or                                 | as a consequ                                 | ence of):        |              |                      |                         |              |                       |                                  |                |   |
|  | Ea            | (Disease or injury that initial events resulting in death) I |  | as a consequ                                 | ence of):        |              |                      |                         | _            |                       |                                  | -              |   |
| xecuted<br>1 and<br>- transit  |               |  | d  |  |                  |              |                      |                         |              |                       |                                  |                |   |
| lal ai e e   | /Medical      | UNPENDED   | AMENDI                                     | ED   |                  |              |                      |                         |              |                       |                                  |                |   |
|  | 3             | IF FEMALE:<br>23b. Was decedent pregnan                      | t in the                                   | res, outcome o                               | of pregnancy     |              |                      |                         |              |                       | 23d. Date of c                   | -              | (2) 2) L                                      |
| OX 68' ath certifi   | Sa            | past 12 months?  | '   '                                      | ve birth<br>regnant at tim                   | e of death 5     |              | death 3<br>(Specify) | Ectopic                 | c pregnancy  |                       | Month                            | Da             | ay Year                                       |
| BOX<br>e death<br>the atte<br>ed for   | Physiciar     | 1 Yes 2 No 9   | Hakaayaa ==                                | nknown                                       |                  | Otner        | (Specify)            |                         |              |                       |                                  |                |   |
| o d by t   |               | Part II. Other significant co                                | onditions contribution                     | ng to death bu                               | ıt not resulting | g in the und | erlying cause        | given in Pa             | art I.       | 23e. Did tob          | acco use contrib                 | ute to th      | ne cause of death?                            |
| s, P.O.<br>nires that the<br>signed by<br>d be detach  | ğ<br>b        | · · · · · · · · · · · · · · · · · · ·                        |  |  |                  |              |                      |                         |              | 1 Yes                 | 2 <b>V</b> No 3                  | Proba          | ably 4 Unknown                                |
| ords<br>w requires<br>s been s<br>should   | Set           |  |  |  |                  |              |                      |                         |              | 24a. Was ar<br>autops |                                  |                | opsy findings available impletion of cause of |
| Reco<br>The law<br>icate has<br>page 2 s   | ompleted      |  |  |  |                  |              |                      |                         |              | perform               |                                  | eath?<br>✔ Yes | 2 No  |
| tal Recise: The certificate ector, page  | BeC           | 25. Was case referred to me                                  |  |  |                  |              | 26.Plac              | ce of Death             | (Check only  |                       |                                  |                |   |
| Vit<br>bysici<br>this c  | 2             | examiner?<br>1 ✔ Yes 2 No                                    | Hospital: 1                                | Inpatient                                    | 2 ER/O           | utpatient 3  | DOA                  | Other4                  | Nursing H    | ome 5 F               | Residence 6                      | Other:         | Scene   |
| Division of Vital Records, P.O. tal or Atteodiog Physiciae: The law requires that the safter death.  al Director: After this certificate has been signed by tee funeral director, page 2 should be deach.  | Ĕ             | 27. Manner of Death  1 Natural 5                             | (M   | Date of Injury<br>Ionth Day Year)<br>4, 2012 | 28b. 0610        | Time of Inju |                      | ury at Work             | . IPa        |                       | ow injury occurreduto auto colli |                |   |
| SiOr<br>Miteo<br>death<br>ctor:  | catic         | 2 Accident   | Investigation                              |  |                  |              |                      | Yes 2                   | NO           |                       |                                  |                |   |
| Divis  | Certification | 3 Suicide 6  | Could not be                               | Place of Injury                              |                  |              | factory, office      | building, etc           |              | or Town, Sta          | ate)                             |                | al Route Number, City                         |
| Cospital hours   |               | 4 Homicide  29a. Certifier                                   | 10,000                                     | cify) Major                                  |                  |              | 1 -445 - 45          |                         |              |                       |                                  |                | Roa, Phoenix, MD                              |
| Division of Vital Records, P.O. Box 68 To the Bospital or Attending Physiciao: The law requires that the death certif within 24 hours after death. To the Fuceral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | Medical       |  | ng Physician: To the<br>Examiner:On the ba | sis of examina                               |                  |              |                      |                         |              |                       |                                  |                |   |
| To Wit   | Μě            | 29b. Signature and title of c                                | and mann                                   | er stated.                                   |                  |              |                      | se number               |              |                       | 29d. Date signed                 |                |   |
| No.  |               | D_~ )  |  |  |                  |              | 0.0                  | .M.E.                   |              |                       | May 4, 2012                      | :              |   |
| 28,  | }             | 30. Name and address of pe                                   | rson who completed                         | cause of deat                                | h (Item 23a)     |              |                      |                         | _            |                       |                                  |                |   |
|  |               | Donna M. Vincent   |  | nt Medical                                   | Examiner         | 900 W        | . Baltimor           | e Street,               | Baltimor     | e, MD 212             | 23                               |                |   |
|  |               | 31. Date filed (Month, Day,)                                 |  | . Registrar's                                | Signature        |              |                      |                         |              |                       |                                  |                |   |
| Regist   | rar           | MAY 1 0 201  | L Church                                   |  | BALL             | 20           |                      |                         |              |                       |                                  |                |   |

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 14901 For State Registrar Certificate of Death 2. Date of Death Time of Death Month Physician/ 20 Medical 4a. Facility Name (if not institution, give street and number City, Town, or Location of Death 4c. County of Death Examiner Glen Battimore Medical ONTER SUNIL Social Security Number . Age (In yrs last birthday) 8. Date of Birth Birthplace (State or Foreign **Funeral** 1 M 2 □ F 216-16-245 (Month, Day, X ani Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at WNIQ 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Barrack 2106 S ane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black. White, etc. δ 1 Never Married 2 Married 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Specify If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Je filed wtu. ⊶al Hygiene. ∽ar than "r Elementary/Segonday (0-12) College (1-4 or 5+) WestingHouse Be Maryland Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SON Va Barrack 19a. Informant's Name/Relationship (Type, Print) SON en Kurnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State Arbutus Man Pork 4 ☐ Donation 5 ☐ Other (Specify) FUNEra 21. Signature of Funeral Service Licensee HOME once, Howell Awittord 20794 Koad 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death -Ph\_sician/ disease or condition Medical resulting in death) Examiner TO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760气头 nding physician and Due to (or as a consequence of) Physician/Medical the IF FEMALE: nse If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an prior to completion death?

1 Yes 2 No performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 25. Was carreferred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Many r of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work?
1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 6 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per 10 mie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State Registrar DHMH 17 Rev 06-2011 only one)

win

d cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decederit's Name (First, Middle, Last) **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death Name (If not institution, dive street and number) 4a. Facility Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country), 8. Date of Birth (Month, Day, if Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Days **Funeral** 1 №M 2 🗆 F 060-56-5032 Director Usual Residence of Decedent 10d. inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 Yes 2 No Examiner must be notified at Director Micott 10g. Citizen of What Country? 10f. Zip-Code 10e, Street and Number 23a or 21040 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Items Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examiner once. 2 N6 1 Never Married 2 Married ☐ Yes 1 ☐ Yes 2 ☐ No ASION Baltimore, Maryland 21215-0036 ≥ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) tronic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21047 19a. Informant's Name/Relationship (Type. Print) OUY 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Teremation 3 Removal from State tanower 4 | Donation 5 Other (Specify) 21. Signature of Funeral Service License New 20794 e 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician disease or condition resulting in death) /Medical ue to ( r as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a nesequence of): the attending physician and ched for use as the burial-transit Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No page 2 should be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₽ 1 Yes 2 No 3 Probably Completed peen a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate has 26. Place of Death Check o one To the Hospital or Attending Physician: 25. Was case referred to medica Be examiner? Other: 4 \sum Nursing Home Hospital: 3 □ DOA 5 ☐ Residence 6 ☐ Other (Specify) Yes 2 🗆 No **Inpatient** 2 - ER/Outpatient ρ Manper of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of filled in by the funeral 27 Certification: Injury Natural Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical and manner stated. 29c License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier eted cause of death (Item 23a) (Type, Print) 30. Nome and address of person

Registrar

State

32. Registrar's Signature

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND\_ITEM#/perffl,G92/,5/23/2012,ws State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Zimmerman 1739 M vonne Eleanor may Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard 8. Date of Birth (Month, Day, Year, 1111 v 5 10 If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 - M 2 - F Hours 407-30-4631 83 82 Yrs. Kentucky Director 1929 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Hanover 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6226 2nd Avenue 21076 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) System Analyst Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Wilson Smith Lewis Thelma Pearl Williamson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah L. Bowie (Daughter) 7258 Stallings Drive Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 5/9/2012 Elkridge, Maryland 22. Name and Address of Facility
Gary L. Kaufman Funeral Home at MMP, Inc.
7250 Washington Blud., Elbridge, MD 21075
used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
each line., 21. Signation of Funeral Service License 23a. Part 1. Enter the disease, or complications the shock, of peart failure. List only one cause of Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate
Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Who

9 Unknown Month Pregnant at time of death 5 Other (specify) After this certificate has been signed by the infunctional director, page 2 should be detached g Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of death? autopsy perform 1 Yes 2 N 2 Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 D Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work?
1 ☐ Yes 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 🗌 No ☐ Accident ☐ Suicide Investigation within 24 hours after death

To the Funeral Director: A 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1110 Medical Campus Rd Ste:1153 Hagerstown, MD, 21742 State Registrar

amend 30 per DVR, g927 5-10-12 sm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 04/22/2012 Barbara Hancock Ailstock 13:20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hartley Hall Nursing Home Pocomoke City Worcester Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 8 Date of Birth 220-16-7512 **Director** 86 1117777771925 Usual Residence of Decedent shov 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f MD Worcester Pocomoke City 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a302 Market St. 21851 USA led within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) .. Page 1 and 2 should I▼ ..lec trment of Health and Mental H tant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) Milton S. Hancock Eva Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Ailstock/Son 331 Ternwing Dr., Arnold, MD, 21012 20a. Method of Disposition 20b. Place of Disposition (Name of Department of I Important: If ite any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place) 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 'irst Bapt. Cemetery Pocomoke City 22. Name and Address of Facility Holloway Funeral Home P.A. Signature of Funeral Service Licensee 107 Vine St., Pocomoke City, MD, 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Orget and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence Exami Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) nding physician a use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery atten for u Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Day Pregnant at time of death the hed 9 Unknown 9 Unknown P.O. signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No After this certificate | 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 2 No Other: ၉ 1 TYes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4. Nursing Home 5 - Residence 6 - Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1- Natural 5 Pending work? ☐ Accident 1 🗌 Yes 2 🗆 No neral Director: A Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 2185 -Market ocomo 31. Date filed (Month, Day, Year) 100 06 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL  $20\overset{\text{Year}}{1}$ BARTHOLOW ETHEL 5:10 РМ M. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DORCHESTER 2625 LANCE DRIVE CAMBRIDGE Social Security Number If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🗓 F Hours OCT. 21, 1916 MARYLAND 215-20-9678 95 Director Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl notified 1 X Yes 2 No MARYLAND DORCHESTER CAMBRIDGE permit. Page 1 and 2 should be filed within 72 hours after death with the I Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be no 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 2625 LANCE DRIVE 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give WHITE 3 X Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MANUFACTURING ASSEMBLY LINE WORKER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ FRANCIS WILLIAM BECRAFT ELLA R. GAMBER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2625 LANCE DRIVE, CAMBRIDGE MD 21613 DORIS M. MILLS/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗌 Burial 2 🗓 Cremation 3 🗌 Removal from State 5 Other (Specify) 4 Donation CREMATORY OF DELMARVA 4/30/2012 DELMAR, DELAWARE 21. Signal re of Fur ral Service Licen Name and Address of Facility
LLER FUNERAL HOME, P. O. BOX 207
6 MAIN STREET, EAST NEW MARKET MD 106 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 3 MINUTES Physician/ STROKE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 X No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \text{Yes} \) 2 \( \text{D} \) No 24a. Was an autopsy performed? Yes 2 X 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 2 X No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred XNatural injury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D50804 APRIL 30, 2012

State Registrar 408 BYRN STREET, CAMBRIDGE MD 21613

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK MALKUS, M.D.,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death BRANAND Physician/ ATRE Month 00:20 Run 1 18 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Min. Hours Director 010-36-7668 1 □ M 2 🏋 F 67 8/23/1944 FLUSHING, NY Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 🗆 Yes 2 😾 No ANNAPOLIS ANNE ARUNDEL MARYLAND 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2110 CHESAPEAKE HARBOR DRIVE #101 21403 UNITED STATES "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Black, White, etc. and 2 should be filed within 72 hours after of Health and Mental Hygiene. Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3X Widowed 4 □ Divorced Specify: Year or Dates WHITE event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of wark done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1.2 College (1-4 or 5+) AUTHOR WRITING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ FRANK DOSTAL CLARA WEIDMANN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WENDY MONROY/DAUGHTER Department of Health Important: If item 2 any injury or other t 21153 PARC DULLES SQUARE #341 STERLING, VA 20166 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE CREMATION 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/24/2012 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LASTING TRIBUTES BY FELLOWS art 1. Enter the disease, or complications that caused shock, or heart fallue. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MIN My se ma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Box 68760 as the attending IF FEMALE: for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available has page 2 prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Yes ပ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier SpeinBuh, our 29d. Date signed (Month, Day, Year) D46052 4/22/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parking, anna polis, to 31. Date filed (Month, Day,

DHMH 17 Rev 06-2011

State

Registrar

32. Fegistrar's Signature

APR 25 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 19, Day 2012 Year Harry E. Bengtson 5:45 A. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Golden Living Center If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** 9. Birthplace (State or Foreign Days Hours 375-48-6492 64 **Director** 1 ★M 2 □ F May 29, 1947 Michigan 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21788 15142 Kelbaugh Road USA 1 and 2 should be filed within 72 hours after death v for Health and Mental Hygiene. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 2X No Baltimore, Maryland 21215-0036 1 
☐ Yes :
If Yes, Give white 1 Yes 2XXNo Specify: Completed 3 ☐ Widowed 4 ☒ Divorced Specify Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Automotive Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Imbie Alida Johnson Bertil Olef Bengston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15142 Kelbaugh Road, Thurmont, Maryland 21788 . Page 1 and 2 sh ment of Health a tant: If item 27 is Sue Strawsburg - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Carcemation 3 Removal from State Stauffer Crematory 4-20-2012 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Sign ure of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 pane 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final KENAL Physician/ TAGE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Attending physician and completely filled in by the Attended for use as the burnal-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 Tes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending injury work 1 Tes 2 Accident
3 Suicide М 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifiei 🜠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) lin Name and address of person who completed cause of death (Item 23a) (Type, Print) Tall House AUE FREDERICK MID 2170

Registrar DHMH 17 Rev 06-2011

State

BTE

KAZMI

Mr 32. Redistrar's Signature

814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April Richard Osborn Butt Pay 1 20ÎZ 1:05 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick 5. Social Security Numbe **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Rirth Days (Month, Day, Year) **Director** 219-54-6466 1 M 2 □ F 63 Dec. 26,1948 Maryland Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 Yes 2 No Maryland Frederick Monrovia 10e. Street and Number 23a or 10f. Zip Code 10g, Citizen of What Country? Funeral 3610 Melinda Court 21770 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner vas Decedent Even Armed Forces? XYes 2 No 'natural", or þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates Vietnam 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Floor Covering Mechanic Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles E. Butt Margaret E. Stang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ige 1 and 2 sh nt of Health a t: If item 27 is Brenda S. Butt/ Wife 3610 Melinda Court, Monrovia, Maryland 21770 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🛮 Burial 2 🗌 Cremation 3 🗎 Removal from State 5 Other (Specify) Monocacy Cemetery 4/20/2012 Beallsville, Maryland. Signature of uneral Service Lice 22. Name and Address of Facility
Stauffer Funeral Homes P.A.
1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Interval Between Onset and Death Immediate Cause (Final Physician/ STROKE disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death Year signed by the at d be detached for Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 2 🗆 No 1 
Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Hospital Other: 2 M No မ 1 🗌 Yes 1 Nonpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred the Hospital or Attending 1 Natural (Month, Day, Year) 5 Pending death. Accident Investigation 1 Yes 2 🗌 No Funeral Director: 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Junea Fractitioner: To the Lest of my knowledge. Seath commed at the time, date and place, and due to the cause(s) and man are as stated. within 2. 29b. Signature and title of co 29d. Date signed (Month, Day, Year) D0035267 Name and address of person who completed cause of death (Item 23a) (Type, Print) St Frederick mp 21701 400 West

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

|                |  |              | 1 = State<br>Registrar  |                               |                | tificate of L                           |                            |                                 | Reg. No        | 201                           | 2   49   1                                       |  |  |  |  |  |
|----------------|--|--------------|---|-------------------------------|----------------|---|----------------------------|---------------------------------|----------------|-------------------------------|--|--|--|--|--|--|
| ľ              | Physicia<br>Medi   |              | 1. Decedent's Name (First, Middle, Last) <b>Edna Louise Be</b>  | rry                           |                |   |                            | 2. Date of De April             |                | y 2012                        | 3. Time of Death  10:00a M                       |  |  |  |  |  |
| , person       | Exami  |              | 4a. Facility Name (if not institution, give street and number)  Calvert Manor Health Ca   |                               | <b>.</b>       | 4b. City, Town, or                      |                            |                                 |                | County of De                  | ath  |  |  |  |  |  |
|                | Funeral  |              |   | re Cen                        |                | Risin If Under 1 Year                   | _                          | 8. Date of Bi                   | rth            | Cec                           | irthplace (State or Foreign                      |  |  |  |  |  |
| le.            | Director   |              | 221-46-6686  Usual Residence of Decedent  | 87                            | Yrs.           | Months Days                             | Hours Min                  |                                 |                | 5 Yo                          | orklyn, DE                                       |  |  |  |  |  |
|                | land<br>show<br>dat  | ţō           | 10a. State 10b. County  | 10c. City, To                 |                |   |                            |                                 |                |                               | 10d. Inside City Limits                          |  |  |  |  |  |
|                | Mary<br>28a-1<br>notifie   | Director     | PA Chester  | Laı                           | ndent          | erg                                     |                            |                                 |                |                               | 1 🗆 Yes 2 🍱 No                                   |  |  |  |  |  |
|                | vith the<br>23a or<br>st be  |              | 10e. Street and Number 313 Indiantown Road  |                               |                | 10f. Zip Code<br>19350                  |                            |                                 |                | izen of What C                | Country?   |  |  |  |  |  |
|                | death vitems   | Funeral      | 11. Marital Status 12. Was Decedent I   | Ever in U.S.                  | 13. V          | Vas Decedent of Hi<br>Yes, specify Cuba |                            | pecify Yes or No-               |                | JSA<br>14. Race - Am          | erican Indian,                                   |  |  |  |  |  |
| 21215-0036     | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | ed by        | 1 Never Married 2 Married  3 X Widowed 4 Divorced  Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.  | No                            |                | Yes, specify Cuba                       |                            | to Rican, etc.)                 |                | Black, Whi<br>Specify:        |  |  |  |  |  |  |
| 15-(           | 72 hou<br>n "natu<br>ledica  | Completed    | 15. Decedent's Education<br>(Specify only highest grade completed)  | 16                            | (Give k        | ent's Usual Occupa                      | ation<br>luring most of wo | rking                           | 16b. Ki        | nd of Business                | s/Industry                                       |  |  |  |  |  |
| 212            | vithin jiene.  |              | Elementary/Secondary (0-12) College (1-4 or 5   | i+)                           | -              | NOT use retired)                        | 0                          | 3                               | D.             | rd For                        | d Company  |  |  |  |  |  |
| pu             | al Hyg<br>d othe   | Be c         | 17. Father's Name (First, Middle, Last)   |                               | 500            | lecary                                  | 18. Mother's Na            | me (First, Middle,              |                |                               | а сощрану  |  |  |  |  |  |
| Уlа            | uld be<br>Ment<br>narke  | 오            | John R. Fulton  |                               |                |   | Eliz                       | abeth Ge                        | ebhar          | t                             |  |  |  |  |  |  |
| Maryland       | 2 shouth and the and traum traum   | j            | 19a. Informant's Name/Relationship (Type, Print)  Joseph Fanning (son)  | 11                            |                | g Address (Street a                     |                            |                                 |                |                               |  |  |  |  |  |  |
| re,            | 1 and<br>of Heal<br>item   |              | 20a. Method of Disposition  | 20b. Place                    | of Dispos      | Indianto                                |                            | Lander<br>Date                  |                | PA<br>cation - City o         |  |  |  |  |  |  |
| Baltimore,     | it. Page<br>rtment o<br>rtant; If<br>njury or  |              | 1 Structural 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) *  | ceme                          | elawn          | Mem. Pa                                 | rk 4/2                     | 6/2012                          | New            | Cast1                         | e, DE  |  |  |  |  |  |
| Ba             | Depar<br>Impo<br>any ir  |              | 21. Signature of Funeral Service Licensee   | 55,                           | 22.<br>C       | Name and Addres                         | s of Facility McC          | rery & E                        | larra          | Funera                        | al Homes &                                       |  |  |  |  |  |
|                | Physician<br>Medical   |              | 23a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due tr (or as a consequence of): |                               |                |   |                            |                                 |                |                               |  |  |  |  |  |  |
|                | Examiner   | <u>.</u>     | Sequentially list conditions, b.  | entia                         |                |   |                            |                                 |                |                               | years  |  |  |  |  |  |
|                | led<br>nsit  | Examiner     | if any, leading to immediate Due to (or as a cauca. Enter Underlying Cause (Disease or injury   | consequence                   | e of):         |   |                            |                                 |                |                               |  |  |  |  |  |  |
|                | ificate be executed groups by physician and as the burial-transit  | Exa          | that initiated events c. Due to (or as a  | a consequence                 | e of):         | <del></del>                             |                            |                                 |                | _                             |  |  |  |  |  |  |
| 8760           | ate be<br>hysicia<br>the bu  | Medical      | d   |                               |                |   |                            |                                 |                |                               |  |  |  |  |  |  |
|                | <u> —</u> თ. დ   |              | IF FEMALE: 23b Was decedent pregnant 23c. If yes, outcome   | of pregnancy                  |                |   |                            | _                               |                |                               |  |  |  |  |  |  |
| Box            | requires that the death cert<br>been signed by the attendin<br>should be detached for use  | Physician/   |   | 2 Fetal dea                   |                | Ectopic pregnancy<br>Other (specify)    |                            | - 00-                           | 2              | 3d. Date of de<br>Month       | elivery<br>Day Year                              |  |  |  |  |  |
| О.             | requires that the<br>been signed by the<br>should be detach  | by P         | Part II. Other significant conditions contributing to death be  | ut not resulting              | g in the un    | derlying cause give                     | en in Part I.              | 23e. Did to                     | bacco us       | se contribute to              | the cause of death?                              |  |  |  |  |  |
| ds,            | quires<br>en sig<br>ould b   |              |   |                               |                |   |                            | 1 🗆 '                           | Yes 2          | No 3□P                        | robably 4 <b>Tu</b> nknown                       |  |  |  |  |  |
| ပ              | law re<br>has be<br>re 2 sh  | Completed    |   |                               |                |   |                            | 24a. Was autop                  | sy             | 24b. Were au                  | itopsy findings available completion of cause of |  |  |  |  |  |
| ř              | sician; The law a<br>certificate has b<br>lirector, page 2 s   |              | 25. Was case referred to medical  |                               |                |   |                            | 1 Yes                           | rmed?<br>2 No  | death?<br>1 ☐ Yes             | s 2 No   |  |  |  |  |  |
| VIta           | ysicia<br>is certi<br>direct   | To Be        | examiner?   | ent 2 🗆 ER/C                  | Outnationt     | Othor                                   | ce of Death (Che           | ok only one)                    |                | 7 011 - 10                    | ~  |  |  |  |  |  |
| ō              | ng Fn<br>fter thi<br>uneral  |              | 27. Manner of Death 1 Natural 5 □ Pending (Month, Day,  | y 28b.                        | Time of injury | 28c. Injury work?                       |                            | 28d. Describe h                 |                |                               | siry)  |  |  |  |  |  |
| lois           | death<br>death<br>stor: A<br>y the fi  | Certificate: | 2 Accident Investigation 3 Suicide 6 Could not be   |                               |                | M 1 🗆 Y                                 | ′es .2 □ No                |                                 |                |                               |  |  |  |  |  |  |
| Division       | all or A<br>safter<br>Direction by   |              | 4 Homicide determined 28e. Place of Injurbuilding, etc.   | y - At nome, f<br>. (Specify) | tarm, stree    | it, factory, office                     |                            | 28f. Location (S<br>City or Tow |                | Number or Ru                  | ral Route Number,                                |  |  |  |  |  |
| T Chicagon     | or the robspiral or Attending Physician; within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,  | ledical      | 29a. Certifier 1 Certifying Physician: To the best of r (Check only one) 3 Certifying Nurse Practitioner: To the  | an ination and                | zor investic   | latton, in my opinion                   | i, deam occurred a         | at the time date at             | ad place a     | and due to the                | calleg(e) and mannor stated                      |  |  |  |  |  |
| 70             | vithin<br>Vithin<br>To the<br>comp   | Σ            | only one) 3 Certifying Nurse Practitioner; To the 29b. Signature and title of certifier   | best of my kno                | iówiedge, d    | 29c. License r                          |                            |                                 |                | and manner a<br>signed (Month |  |  |  |  |  |  |
|                |  |              | > Sachden-5. MD   |                               |                | D0083                                   | 3322                       | 22 4/24/2012                    |                |                               |  |  |  |  |  |  |
|                | 1  |              | 30. Name and address of person who completed cause of de S.S. Sackdey MD, 126,  | ath (Item 23a)<br>4 E Co.     | (Type, Pri     | lve. E                                  | Chilm                      | MD 2192                         | <del>/</del> / |                               |  |  |  |  |  |  |
| W <sub>2</sub> | Stat<br>Registra   | 7            | 31. Date filed (Month, Day, Year)  APR 2 6 2012.  | 's Signature                  | A. A           | barker                                  |                            |                                 |                |                               |  |  |  |  |  |  |

|  |                  | For State Registrar   | lease 1                            |  |             |                                     | Depa                     |  | t of H         | łealth                     |                        | <b>III Copi</b> e<br>Mental H                     |  | ne 2.0                           | ble.                   | >   4                                      | 91                     |
|--|------------------|---|------------------------------------|--|-------------|-------------------------------------|--------------------------|--|----------------|----------------------------|------------------------|---|--|----------------------------------|------------------------|--|------------------------|
| Physicia<br>Medic  |                  | 1. Decedent's Name (First, N<br>Robert F  | ussel                              |  | ley         |                                     |                          |  |                |                            |                        | 2. Date of D                                      | eath                                       | Day \                            | Year.                  | 3. Time of 063                             |                        |
| Examin   | ier              | 4a. Facility Name (if not instit<br>WM. Regional  |                                    |  | ,           |                                     |                          |  |                | Location<br>land           |                        |   |  | ac. County of Allega             | Death<br>ny            | 1  |                        |
| Funeral<br>Director  |                  | 5. Social Security Number 219–44–0072  Usual Residence of Decede  |                                    | <b>K</b> M 2 □ F   |             | n yrs. last b<br><b>7</b>           | irthday)<br>Yrs.         | If Under<br>Months                                 | 1 Year<br>Days | If <u>Under</u><br>Hours   | Min.                   | 8. Date of E<br>(Month, I<br>March                | Birth<br>Day, Year<br>25                   | 1945                             | Cou                    | nplace (State ontry)<br>ryland             | or Foreign             |
| e Maryland<br>r 28a-f sho<br>notified at   | Funeral Director | 10a. State 10b. Co MD Gar  10e. Street and Number   | rett                               |  | 1           | 0c. City, To                        | wn or Loc                | gton   | Cada           |                            |                        |   |  |                                  |                        |  | ity Limits<br>s 2 🗌 No |
| n with th  | nerall           |   | st.                                |  |             |                                     |                          | 10f. Zip<br>21                                     | 523            |                            |                        |   |  | citizen of Wh                    |                        |  |                        |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show ampiritupy or other traumatic event, the Medical Examiner must be notified at once.  | by               | 11. Marital Status<br>1 ☐ Never Married 2 🗗<br>3 ☐ Widowed 4 ☐ Divo   | Married                            | 2. Was Dece<br>Armed Fo<br>1 XYes<br>If Yes, Giv<br>Year or Da | rces?       |                                     | - 11                     |  | ify Cubar      | n, Mexica                  | n, Puerto              | ecify Yes or No<br>Rican, etc.)                   | )-   | 14. Race -<br>Black,<br>Specify: | White                  | ican Indian,<br>, etc.<br>nite             |                        |
| within 72 hou<br>giene.<br>ier than "nat<br>is, the Medica   | Completed        | 15. Dec<br>(Specify only in<br>Elementary/Secondary (0-<br>12   |                                    |  |             | 16                                  | (Give k<br>life. D(      | ent's Usua<br>ind of wor<br>NOT use<br><b>iner</b> | k done d       |                            | st of worki            | ing   |  | Kind of Busi                     | ness/l                 | ndustry                                    | . <u>.</u>             |
| d be filed<br>Mental Hy<br>arked oth<br>atic event   | To Be            | 17. Father's Name (First, Midd<br><b>John</b> Bo  | dle, Last)<br>esley                |  |             |                                     |                          |  |                |                            | er's Name<br>dres:     | e (First, Middl<br>S Eli:                         | <sub>e, Maide</sub><br>zabe                |                                  | Llio                   | ott  |                        |
| nd 2 shoul<br>ealth and<br>m 27 is m   |                  | 19a. Informant's Name/Relat<br>Shirley Bosl   | ey/ w                              | ife  |             | 19                                  | 9b. Mailin<br><b>206</b> | g Address<br><b>Nort</b> h                         | (Street a      | nd Numb<br>Blo             | er or Rura<br>omin     | gton, I   | er, City<br>Mary                           | or Town, Star<br>Land 2          | te, <i>Zip</i><br>2152 | Code)<br>23                                |                        |
| Page 1 alment of H<br>tant: If itel  |                  | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth  |                                    | emoval from  | State       | 20b. Place<br>ceme:<br><b>Cumbe</b> | tery, crem               | atory or o   | ther place     | e)<br>ory                  |                        | Date 7/2012                                       | 1  | Location - C<br>mberla           |                        | Town, State<br>Maryla                      | and                    |
| permit<br>Depart<br>Impor<br>any inj   |                  | 21. Signature of Funeral Serv   | rce Licensee                       | Inl  | )           |                                     |                          | . Name an  |                |                            |                        | oal Fu<br>ternpo                                  |  |                                  |                        | 21562                                      |                        |
| cath certificate be executed  Shaking physician and attending physician and for use as the burial-transit  To use as the partial-transit  To use as the par | al Examiner      | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of): |                                    |  |             |                                     |                          |  |                |                            |                        |   | Approximat<br>Interval Bet<br>Onset and II | ween<br>Death                    |                        |  |                        |
| ficate be<br>g physic<br>as the b  | <b>Jedic</b>     |   | d.                                 |  |             |                                     |                          |  |                |                            |                        |   |  |                                  |                        |  |                        |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate be within 24 hours after death. After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the bu  | Physician/Medic  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23                                 |  | Birth 2 (   | pregnancy<br>Petal deame of death   |                          | Ectopic p<br>Other <i>(sp</i>                      |                | y                          |                        |   |  | 23d. Date                        |                        | -  | Year                   |
| uires that the dea<br>in signed by the a<br>uld be detached f  | by               | Part II. Other significant cor  | ditions cont                       | ributing to d  | eath but i  | not resulting                       | g in the ur              | nderlying o  | ause give      | en in Part                 | l.                     |   |  |                                  |                        | the cause of d                             | _                      |
| : The law require<br>cate has been s<br>; page 2 should  | Completed        |   |                                    |  |             |                                     |                          |  |                |                            |                        |   | opsy<br>formed?                            | prid<br>dea                      | or to co<br>ath?       | opsy findings a<br>ompletion of c<br>2  No | available<br>ause of   |
| ysician:<br>ils certific<br>director,  | To Be            | 25. Was case referred to med examiner?  1 ☐ Yes 2 ☐ No  |                                    | espital:   | Inpatient   | 2 🗆 ER/0                            | Outpatien                | 3 DC   | Othe           |                            | th (Check<br>ursing Ho | ne 5 Res  | sidence                                    | 6 Other                          | Specif                 | iv)  | <del></del>            |
| To the Hospital or Attending Phywithin 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral  | Certificate:     |   | nding<br>estigation<br>ould not be |  | th, Day, Y  | ear)                                | Time of injury           | М  |                | at                         | l No                   | 28d. Describe                                     | how inju                                   | ary occurred                     |                        |  |                        |
| oital or A<br>urs after<br>ral Direc<br>illed in by  |                  |   | termined                           | buildir  | ng, etc. (S |                                     |                          |  |                |                            |                        | City or To  | wn, Sta                                    | te)                              |                        | il Route Numb                              | oer,                   |
| the Hosp<br>thin 24 ho<br>the Fune<br>mpletely i   | Medical          | (Check 2 ☐ Medic<br>only one) · 3 ☐ Certif  | al Examine<br>ying Nurse I         | r: On the bas  | is of exam  | nigation and                        | /or investi              | gation, in n<br>death occu                         | rred at th     | n, death oo<br>ie time, da | ccurred at             | nd due to the<br>the time, date<br>ce, and due to | and place<br>the caus                      | ce, and due to<br>se(s) and man  | the ca                 | ause(s) and mai<br>stated.                 | nner stated            |
| <b>5</b>   | ι Δ              | 29b. Signature and title of cer   | titier /                           | m  | 2           |                                     |                          |  | License 36     | number 7 6                 | 6                      |   |  | oate signed (A                   |                        | Day, Year)                                 |                        |
| 4  | VA<br>2          | 30. Name and address of per<br>Dr. Vikramad   | itya P                             | npleted caus<br>Poonai   | e of deat   | h (Item 23a)<br>4 Seto              | ) (Type, Pr              | rint)  |                |                            | ,-                     | MD 21   | 502  | 3                                |                        |  |                        |
| Stat<br>Registra   |                  | 31. Date filed (Month, Day, Ye APR 17   | ar)                                |  |             |                                     |                          | _  |                |                            |                        |   |  |                                  |                        |  |                        |
|  |                  |   |                                    | 1  |             |                                     |                          |  |                |                            |                        |   |  |                                  |                        |  |                        |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                            |  |              | State of Maryland / Dep  | partment of Health and Nertificate of Death                        |   | 2012  | 11013                           |  |  |  |  |  |  |  |
|----------------------------|--|--------------|--|--|---|---|---------------------------------|--|--|--|--|--|--|--|
|                            |  |              | Registrar  1. Decedent's Name (First, Middle, Last)  | itilicate of Death   | 2. Date of Death                          | g. No. / U /  | 14913                           |  |  |  |  |  |  |  |
|                            | Physicia<br>Medi   |              | Kelly Jo BELL  |  | Month                                     | 2) ZOIZ   | 3. Time of Death                |  |  |  |  |  |  |  |
| -                          | Exami  |              | 4a. Facility Name (if not institution, give street and number)   | 4b. City, Town, or Location of Death                               |   | 4c. County of Death   |                                 |  |  |  |  |  |  |  |
| 1                          |  |              | Meritus Medical Center   | Hagerstown   |   | Washingt  | on                              |  |  |  |  |  |  |  |
|                            | Funeral<br>Director  |              | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 □ M 2 🖫 F 7. Age (In yrs. last birthday, 1 □ M 2 🖫 F 7. Age (In yrs. last birthday, 1 □ M 2 🖫 F 7. Age (In yrs. last birthday, 1 □ M 2 🖫 F 7. Age (In yrs. last birthday, 1 □ M 2 🖫 F 7. Age (In yrs. last birthday, 1 □ M 2 🖫 F 7. Age (In yrs. last birthday, 1 □ M 2 🖫 F 7. Age (In yrs. last birthday, 1 □ M 2 № F 7. Age (In yrs. last birthday, 1 □ M 2 № F 7. Age (In yrs. last birthday, 1 □ M 2 № F 7. Age (In yrs. last birthday, 1 □ M 2 № F 7. Age (In yrs. last birthday, 1 □ M 2 № F 7. Age (In yrs. last birthday, 1 □ M 2 № F 7. Age (In yrs. last birthday, 1 □ M 2 № F 8. Age (In yrs. last birthd | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.           | 8. Date of Birth<br>(Month, Day, Ye       | 9. Birthp<br>Coun   | place (State or Foreign<br>try) |  |  |  |  |  |  |  |
|                            |  | 1            | Usual Residence of Decedent 1 □ M 2 🖫 F 47 Yrs.  |  | April 9 1                                 | 1965 Mary   | land                            |  |  |  |  |  |  |  |
|                            | /land<br>f sho   | ţo           | 10a. State 10b. County 10c. City, Town or L  | ocation  |   | 1   | 0d. Inside City Limits          |  |  |  |  |  |  |  |
|                            | Mar.<br>28a-<br>notifie  | Director     | Maryland Washington Hagersto   |  |   |   | 1 🌠 Yes 2 □ No                  |  |  |  |  |  |  |  |
|                            | ith the  |              |  | 10f. Zip Code  | 100                                       | g. Citizen of What Coun   | try?                            |  |  |  |  |  |  |  |
|                            | ems  | Funeral      | 801 Forest Drive  11. Marital Status 12. Was Decedent Ever in U.S. 13.   | 21742 Was Decedent of Hispanic Origin? (Spe                        | ocify Voc or No.                          | USA   |                                 |  |  |  |  |  |  |  |
| ဖွ                         | or its   |              |  | If Yes, specify Cuban, Mexican, Puerto                             | Rican, etc.)                              | 14. Race - Americ<br>Black, White, e  |                                 |  |  |  |  |  |  |  |
| 21215-0036                 | within 72 hours after death with the Maryland glene.<br>er than "natural", or items 23a or 28a-f show<br>the Medical Examiner must be notified at  | Completed by | 3 Widowed 4 Divorced If Yes, Give Year or Dates.   | 1 ☐ Yes 2 🛣 No Specify:  |   | Specify: Whi  | te                              |  |  |  |  |  |  |  |
| 15-                        | 72 ho<br>n "nat<br>ledica  | nple         | 15. Decedent's Education 16a. Dece<br>(Specify only highest grade completed) (Give   | edent's Usual Occupation<br>kind of work done during most of worki | ing 16                                    | bb. Kind of Business/Ind  | lustry                          |  |  |  |  |  |  |  |
| 12                         | led within<br>Hygiene.<br>other than<br>ent, the N   | Col          | Elementary/Secondary (0-12) College (1-4 or 5+) If 2   | DO NOT use retired) ntal Assistant                                 |   | T   | • .                             |  |  |  |  |  |  |  |
| bo                         | led v<br>Hyg<br>othe   | Be           | 17. Father's Name (First, Middle, Last)  |  | e (First, Middle, Mai                     | Family Den  | ıstry                           |  |  |  |  |  |  |  |
| ylar                       | uld be fil<br>Mental<br>narked<br>artic eve  | မ            | JackW. Coffelt   | Audrev   | E. Lesher                                 | •   |                                 |  |  |  |  |  |  |  |
| Maryland                   | should<br>and Me<br>is marl  |              | 19a. Informant's Name/Relationship (Type, Print) 19b. Mail   | ing Address (Street and Number or Rura                             |   |   | ode)                            |  |  |  |  |  |  |  |
| e)                         | 1 and 2 should be fi<br>if Health and Mental<br>item 27 is marked<br>other traumatic ev  |              |  |  |   |   |                                 |  |  |  |  |  |  |  |
| Baltimore,                 |  |              | 1 X Burial 2 Cremation 3 Removal from State  | matory or other place) 5 /   |   |   |                                 |  |  |  |  |  |  |  |
| altin                      | permit. Page<br>Department o<br>Important; If<br>any injury or<br>once.  |              |  | ormed Cn. Cem.   |   |   | Taryrand                        |  |  |  |  |  |  |  |
| ñ                          | permit. Departr Importa any inji   |              |  |  |   |   | land                            |  |  |  |  |  |  |  |
|                            |  |              | 23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.   | er the mode of dying, such as cardiac o                            | or respiratory arrest,                    | ,   | Approximate                     |  |  |  |  |  |  |  |
|                            | Physician/   |              | Immediate Cause (Final disease or condition  | Breat Can  | cen                                       |   |                                 |  |  |  |  |  |  |  |
| j                          | Medical Examiner   |              | Immediate Cause (Final disease or condition resulting in death)  Onset a Due to (or as a consequence of):  |  |   |   |                                 |  |  |  |  |  |  |  |
| E                          |  | er           | Sequentially list conditions, if any leading to immediate  |  |   |   |                                 |  |  |  |  |  |  |  |
|                            | ted<br>Insit   | Examiner     | cause. Enter Underlying Cause (Disease or injury   |  |   | vn, Maryland 21740  20c. Location - City or Town, State Hagerstown, Maryland ch Funeral Home agerstown, Maryland rry arrest, Approximate interval Between |                                 |  |  |  |  |  |  |  |
|                            | execu<br>an and<br>rial-tra  | Ex           | that initiated events c. Due to (or as a consequence of):  |  | <u></u>                                   |   |                                 |  |  |  |  |  |  |  |
| 09                         | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Of the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | dical        | d  |  |   |   |                                 |  |  |  |  |  |  |  |
| 387                        | intifica<br>ling ph  | /Me          | IF FEMALE:   |  | 210                                       |   |                                 |  |  |  |  |  |  |  |
| ) XO                       | ath ce<br>attend<br>for us   | cian         | 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No  23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 [ Pregnant at time of death 5 [   | Ectopic pregnancy  |   | 23d. Date of delive   | y<br>Day Year                   |  |  |  |  |  |  |  |
| ň                          | he de<br>y the<br>iched  | Physician/Me | 1   Yes 2 No 4   Fregular at time of death 5 L   | Other (specify)  |   | World   | Jay Teal                        |  |  |  |  |  |  |  |
| P.O. Box 687               | requires that the death certifica<br>been signed by the attending p<br>should be detached for use as I   | y P          | Part II. Other significant conditions contributing to death but not resulting in the   | underlying cause given in Part I.                                  | 23e. Did tobac                            | co use contribute to the  | cause of death?                 |  |  |  |  |  |  |  |
| ds,                        | quires<br>en sig<br>ould b   | Completed by | as severe Namsea and   | Vomiting   | 1 ☐ Yes                                   | 2 No 3 Prob   | ably 4X Unknown                 |  |  |  |  |  |  |  |
| cor                        | aw re<br>as be<br>2 sh   | nple         | (2) Severe Anovexia  | <u> </u>   | 24a. Was an autopsy                       |   | sy findings available           |  |  |  |  |  |  |  |
| Re                         | rsician: The law is certificate has t  | Con          |  |  | performed                                 |   |                                 |  |  |  |  |  |  |  |
| ita                        | sician<br>certifi<br>irecto  | m            | 25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Planation: 2 FP/Outpetion   | 26. Place of Death (Check  | only one)                                 |   |                                 |  |  |  |  |  |  |  |
| of V                       | y Physer this eral d   | e: To        | 27. Manner of Death 28a. Date of injury 28b. Time o  | nt 3 🗆 DOA   4 🗀 Nursing Hor                                       | me 5 Residence                            | e 6 Other (Specify)   |                                 |  |  |  |  |  |  |  |
| ou                         | ath.<br>r: Afte  | icat         | 1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation   | work?<br>M 1 ☐ Yes 2 ☐ No  | .ou. Describe now is                      | njary occurred  |                                 |  |  |  |  |  |  |  |
| Division of Vital Records, | or Atte<br>after de<br>Directo<br>I in by ti   | Certificate: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)  | eet, factory, office   | 28f. Location (Street<br>City or Town, St | t and Number or Rural F   | Route Number,                   |  |  |  |  |  |  |  |
| ٥                          | oital o  |              |  |  |   | ,   |                                 |  |  |  |  |  |  |  |
| :                          | To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page   | Medical      | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or investigations).   | tigation, in my opinion, death occurred at a                       | the time date and nl                      | ace and due to the cause  | a(e) and manner etated          |  |  |  |  |  |  |  |
|                            | To the within 2 To the comple  | Σ            | only one) 3 Certifying Nurse Practitioner: To the best of my knowledge 29b. Signature and title of certifier   | 29c. License number  |   | use(s) and manner as sta<br>Date signed (Month, Date  |                                 |  |  |  |  |  |  |  |
|                            | W.   |              | KUNDA M.D  | 80069606   |   | pril, 20  | 1 2012                          |  |  |  |  |  |  |  |
|                            | ~  | İ            | 30. Name and address of person who completed cause of death (Item 23a) (Type, F  | Print) RICHARD K   | ODUAH                                     |   | , 2012                          |  |  |  |  |  |  |  |
|                            |  |              | 324 East Antietan St., #350  | , Hagerstown   |   | 2174  | 5                               |  |  |  |  |  |  |  |
|                            | Stat<br>Registra   | e<br>ır      | 31. Date filed (Month, Day, Year) 2012 32. Fegistrar's Signature   |  |   |   |                                 |  |  |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alice Geneva Brown Month Day 9:04A M 4 2012 Medical 4a. Facility Name (if not institution, give street and number)
Fort Washington Hospital Examiner 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Prince Georges Social Security Number yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 579-66-5165 1 🗆 M 2 🔀 F (Month, Day, Year) 7/16/1917 Director Maryland Usual Residence of Decedent show 10b. County a. State 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits Funeral Director Washington 28a-f 1 XYes 2 No <sup>10</sup>2494 Alabama Ave. SE #201 10f. Zip Code 20020 5 10g. Citizen of What Country? 23a USA items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 5 þ 1 X Never Married 2 Married 1 Yes 2X No If Yes, Give Year or Dates. 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify Specify: Black "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) id Mental Hygiene. marked other tha the Monetary Printer Government Printing traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F John Brown ပ Ellnora Savoy 19a. Informant's Name/Relationship (Type, Print)
Earl Genies/Cousin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Redwood Branch Ct. Clinton, MD. 7201 1 and 2 s of Health item 27 20735 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Heritage Cem. 20c. Location - City or Town, State Date Page 1 9 1 XBurial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4/24/12 Waldorf, MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dunn & Sons-5635 Eads St. NEWashington MO1388 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) INKN OWA Medical Examiner Secuentially list randitions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury requires that the death certificate be executed and that initiated events resulting in death) Last as the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò þe 1 🗌 Yes 2 🗋 No 3 🔲 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law this certificate has page 2 autopsy perform 2 🗌 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 2 မ 1 Impatient 2 4 Nursing Home 5 Residence 6 Other (Specify ER/Outpatient 3 DOA Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Funeral Director: After 1 Hatural 2 Accident (Month, Day, Year) 5 Pending death. M 1 Tes 2 No Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by after determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one) within To the 000 29b. Signature Name and address of person who comple Samuel Kleimanpleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Date filed (Month,

Livingston Rd. Fort Washington,

20744

MD.

11711

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

For State Registrar 1. Decedent's Name (First, Middle, Last) Physician/ Month 18:05 M lerpell Medical Dunty of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Washington Medical G Ft. Washington CENTER Social Security Number 7. Age (In yrs. last birthday) Yrs. 8. Date of Birth 6 (Month, Day, Year) 6 12 - 1983 If Under 1 Year If Under 24 Hrs **Funeral** 9. Birthplage (State or Foreign 438-49-8513 2 🗆 F Hours Country) **Director** Usual Residence of Decedent show 10a. State 10b. Count notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f NOX 1 Yes 2 No ö 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral SON Bridge 0745 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 3 Widowed 4 Divorced Black, White, etc. þ Baltimore, Maryland 21215-0036 Yes Specify: Black If Yes, Give Year or Dates. 1 Yes 2 No Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) 2 should be filed within 72. h and Mental Hygiene. **7 is marked other than "**r during most of working Elementary/Seconday (0-12) College (1-4 or 5+) ecurit PREVENTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည JUKNOWN Jacquellive other traumatic 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is 1 any injury or Atlant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) *TUNE* JOYCE W. JOHNSON #4102 Hey andivia Druse Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Alexandria Jandemof Memorues -30-201 Donation 5 Other (Specify) OUISIGNIA 21. Signatur 22. Name and Address of Facility WISEMON FUNERAL I tume 2073 1527 Old Hexanding Farry Road Clinton MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ACUTE disease or condition UNKROWA Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions n any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examin -transit that the death certificate be executed Immunoa Due to (or as a consequence of) resulting in death) Last burial Physician/Medical P.O. Box 68760 Phy attending IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month Day Year signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Miknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page perform 1 Yes 2 No Yes 2 25. Was case referred to medical completed filled in by the funeral director. Be 26. Place of Death (Check only one) Hospital Other: 1 Tes 욘 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending injury 1 Yes 2 No Investigation M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signa ted cause of death (Item 23a) (Type, Print) 44705 711 FEWASHINGTONIO

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 2012 04 В. Boyd Medical Frances 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton
If Under 1 Year | If Under 24 Hrs. <u>8513 Shorthills Drive</u> 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (In vrs. last birthday **Funeral** Months Days Hours 1 🗆 M 2 🕱 F 578-38-0817 **Director** 85 Carolina 05/10/1926 North Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 X Yes 2 □ No MD Clinton Prince George's 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 8513 Shorthills Drive 20735 · death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 'n, 1 Never Married 2 Married þ Maryland 21215-0036 hours after 1 Yes 2 No Specify If Yes Give "natural", 3 Widowed 4 X Divorced Completed Black Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry 721 and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Retail <u>Accountant</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Opheila Cathey Floyd Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health an
Important: If item 27 is
any injury or other trans 8513 Shorthills Drive Clinton, MD <u> Jacqueline Coleman - Daughter</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 4/27/2012 Bladensburg. Marv1and 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature of Funeral Service Licensee Montgomey Haus 3401 Bladensburg Road Brentwood. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Immediate Cause (Final Onset and Death MONTHS Fibrosis Physician/ Pulmonary resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician at the burial-Physician/Medical P.O. Box 68760 attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No 5 Other (specify) Month Day Year Pregnant at time of death ed by the a detached i 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Mellitus type 2 Records, Diabetes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law page 2 s autopsy performed? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 😿 No 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA ည funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident Completed filled in by the 3 Sulcide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 Certifying Physician: 🏗 the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: Of the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) PR 2 82012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Olano 110 Irving Street NW Washington, DC 20010

29c. License number

MD036405

29d. Date signed (Month, Day, Year)

04/24/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5 Hona 13.800145 MATY 2 0°1°2 3:40A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES CHAS. COUNTY NURSING & REHAB. LA PLATA 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) 578-54-5750 **Director** 1 🗆 M 2 😿 F 91 OCT.17,1920 NEW YORK 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 XYes 2 No MD CHARLES LA PLATA 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Examiner must be 23a 10200 LA PLATA ROAD 20646 U. S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 0 þ 1 Never Married 2 Married ltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 X Widowed 4 □ Divorced Completed WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) COMPUTER PROGRAMER U.S. GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F မ other traumatic JOSEPH SPIELMAN THERESA M. KESSLER 19a. Informant's Name/Relationship (Type, Print) DAUGHTER, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jefmit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau FREDERICA A. FOXWELL 9555 IRONSIDES ROAD NANJEMOY, MD 20662 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MAY Date 1 Burial 2XX remation 3 Removal from State METRO . CREMATORY 3, 2012 ALEXANDRIA, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death 1080 Ph. sician/ OUL disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Demer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine tal or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician use as the burial Physician/Medical P.O. Box 68760 use as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Live Birth 2 Fetal death ξ Year Month Dav Pregnant at time of death the ed by detac signed k 23e, Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has I autopsy discraler Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 2 No 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending ithin 24 hours after death.

the Funeral Director: Aformpletely filled in by the fu Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within To the comple 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 05/03/2012 10 Bu of death (Item 23a) (Type, Print) from Blud SteB, Glen Burnie, mo Name and address of person who completed cau-Justin Vazha Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death COLDER Physician/ ANN TAT : MOAM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GENERAL LUMBIA HOWARI WARD YTINO If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours Director 213-36-9948 1 M 2 X F 74 1937 Oct 17, Maryland show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County must be notified at Director 28a-f 1 Yes 2 X No MD Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number Funeral items 23a 9721 Hillsmere Road 21042 United States death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status "natural", or iter edical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after 3 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Yes. Give 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. other than " College (1-4 or 5+) Elementary/Secondary (0-12) Education Teacher if Health and Mental Hygie item 27 is marked other other traumatic event, the other traumatic event, the other traumatic event, the other traumatic event, the other traumatic event, the other traumatic event, the other traumatic event, the other traumatic event, the other traumatic event, the other traumatic event, the other traumatic event, the other events event Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Grover Charles Orth Naerie Chandler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9721 Hillsmere Road Ellicott City, Maryland 21042 Neale Gordon Colder/husband 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State o = . 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Important: I any injury o Ardent Cremation Svc. 4/28/2012 Hanover, Maryland 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Signature of Funeral Service Licensee uanta 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Pand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner NE Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury CAILURE CONGESTIVE and as the burial-trai that initiated events Due to (or as a consequence of) resulting in death) Last physician Be Completed by Physician/Medical ENALFAILURE the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IE EEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Month Year Pregnant at time of death 1 Yes 2 Dunknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FIBRILLATION 2 No 3 Probably 4 Unknown 1 🗌 Yes IMMUNE HEPATIT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 autopsy performed? 1 Pes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Medical Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours ofter death. Funeral Director A 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) / filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completely 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) D0064539 altre 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KANOMURU, 5755 CEDAR LANE, COWMBIA,

Registrar

State

APR 2 6

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                |  |              | For   | State o                       | f Marylan                                     | -                   | artment of I                             |                      | and Me                          | ental Hyg                               | giene                        |                     |                                 |
|----------------|--|--------------|---|-------------------------------|---|---------------------|--|----------------------|---------------------------------|---|------------------------------|---------------------|---------------------------------|
|                |  |              | State<br>Registrar  |                               |   | Cer                 | tificate of l                            | Death                |                                 |   | Reg. No. 2                   | NI                  | 2 1691                          |
| т              | Physicia   | n/           | Decedent's Name (First, Middle, La  | ,                             |   |                     |  |                      |                                 | <ol><li>Date of Dea<br/>Month</li></ol> |                              | Year                | 3. Time of Death                |
|                | Medic  | al           |   | James Jo                      |   | avanau              |  |                      |                                 | April                                   |                              | Year<br>2           | 0921 A <sup>M</sup>             |
|                | Examir   | er           | 4a. Facility Name (if not institution, give                                     |                               | ,   |                     | 4b. City, Town, o                        |                      |                                 |   | 4c. County                   |                     |                                 |
| "MODIFY"       | Funeral  |              | Glorious  5. Social Security Number 6. S  |                               | L <b>LC</b><br>7. Age (In yrs. Ia             | ast birthday)       | If Under 1 Year                          | amasc<br>If Under    |                                 | 8. Date of Birt                         |                              |                     | gomery uplace (State or Foreign |
|                | Director   |              | 498-05-5279   | <b>●</b> M 2 □ F              |   | Yrs.                | Months Days                              | Hours                | Min. O                          | ctonth,25                               | Year 916                     | Cour                |                                 |
|                | n o d  |              | Usual Residence of Decedent   |                               | 95  |                     |  |                      |                                 | Nov. 25                                 | <del>,1916</del>             |                     | Iowa                            |
|                | ryland<br>-f sh  | ctol         | 10a. State 10b. County  |                               | 10c. City                                     | y, Town or Lo       | cation                                   |                      |                                 |   |                              |                     | 10d. Inside City Limits         |
|                | r 28a<br>notif   | Director     | Maryland Mont  10e. Street and Number   | gomery                        |   |                     |  | mascu                | .s                              |   |                              |                     | 1 Yes 2 No                      |
|                | with th  | ral          |   | _ 1                           |   |                     | 10f. Zip Code                            | 00000                |                                 |   | 10g. Citizen of V            |                     | ·                               |
|                | ems<br>er mu   | Funeral      | 7115 Damascus Ro  | 1                             | dent Ever in U.S                              | S. 13. V            | Vas Decedent of H                        | 20882<br>ispanic Ori |                                 | fv Yes or No-                           | Unite                        |                     | cates                           |
| 9              | or it  | by F         | 1 Never Married 2 Married   | Armed Fore                    | 2 🗌 No  | 1                   | f Yes, specify Cuba                      | an, Mexicar          | n, Puerto Ri                    | can, etc.)                              |                              | k, White,           |                                 |
| 003            | urs af<br>ural"  |              | 3 ₩idowed 4 Divorced  | If Yes, Give<br>Year or Dat   |   | I 1                 | ☐ Yes 2 No                               | Specify:             | :                               |   | Specify:                     | Whi                 | ite                             |
| 5              | e filed within 72 hours after death with the Maryland<br>tial Hygiene.<br>ed other than "natural", or items 23a or 28a-f show<br>event, the Medical Examiner must be notified at                         | Completed    | 15. Decedent's E<br>(Specify only highest gr                                    |                               |   | (Give I             | lent's Usual Occup                       | during mos           | t of working                    | ,                                       | 16b. Kind of Bu              | siness/Ir           | ndustry                         |
| 21215-0036     | ithin<br>ene.<br>r thar<br>the M   | Con          | Elementary/Secondary (0-12)   | College (1-4                  | 4 or 5+)                                      |                     | O NOT use retired)                       |                      |                                 |   | 0                            |                     | Q                               |
| 9              | filed w<br>all Hygi<br>d other   | Be           | 17. Father's Name (First, Middle, Last)   |                               |   | <u> </u>            | Finance l                                |                      |                                 | First, Middle, I                        | VOU<br>Maiden Surname        |                     | Govt.                           |
| <u>lan</u>     | ould be find Mental marked matic ev  | 욘            | Thomas M. Cavan   | augh                          |   |                     |  |                      | ise L                           |   |                              | ,                   |                                 |
| Maryland       | should be and Me   |              | 19a. Informant's Name/Relationship (7   |                               |   | 19b. Mailin         | g Address (Street                        |                      |                                 |   | City or Town, S              | ate, Zip            | Code)                           |
|                | and 2 s<br>Health<br>tem 27  |              | Thomas M. Cavanau   | gh, Son                       |   | 4 Cha               | let n 22                                 | , 282                | 24 Po                           | zuelo d                                 | de Alarc                     | on,N                | Madrid Espan                    |
| ore            | t of H<br>t of H<br>If itel<br>or oth  |              | 20a. Method of Disposition  1 ■ Burial 2 □ Cremation 3 □                        | Removal from S                |   | lace of Dispo       | sition (Name of<br>natory or other place |                      | Da                              |   | 20c. Location -              | _                   |                                 |
| Baltimore,     | t. Page<br>tment o<br>tant: If<br>ijury or   |              | 4 Donation 5 Other (Special   |                               |   |                     | eaven Cer                                |                      | 04/28                           |   |                              |                     | ng, Maryland                    |
| Ba             | permit. Page 1 and 2 should be<br>Department of Health and Men<br>Important: If item 27 is marke<br>any injury or other traumatic  |              | 21. Signature of Faral Service Lipen  | user &                        | liams   | , P.A.              | , Funera                                 | 1 Ho                 | ome<br>20872                    |   |                              |                     |                                 |
|                |  |              | 23a. Part 1. Enter the disease, or com<br>shock, or heart failure. List only of | plications that ca            |   |                     |  |                      | Approximate<br>Interval Between |   |                              |                     |                                 |
|                | trysician/   |              | Immediate Cause (Final disease or condition                                     |                               | al Deb  | ility               |  |                      |                                 |   |                              |                     | Onset and Death                 |
|                | Medical Examiner   |              | resulting in death)   | Due to (o                     | r as a consequ                                | ence of):           |  |                      |                                 |   |                              |                     |                                 |
|                |  | r.           | Sequentially list conditions,   | b. Demer                      |   |                     |  |                      |                                 |   |                              | _                   |                                 |
|                | ed<br>nsit   | Examiner     | cause. Enter Underlying Cause (Disease or injury                                |                               | cosclar                                       |                     | ardiovaso                                | 11100                | Digo                            |   |                              |                     |                                 |
|                | xecut<br>n and<br>al-tra   | Exa          | that initiated events<br>resulting in death) Last                               | Ç.                            | r as a consequ                                |                     | aruruvasi                                | Julai                | DISE                            | ase                                     |                              | $\dashv$            |                                 |
| 09             | certificate be executed nding physician and use as the burial-transit  | edical       |   | l d.                          |   |                     |  |                      |                                 |   |                              |                     |                                 |
| 978            | ificate<br>ig phy<br>as th   | Med          | IF FEMALE:  |                               |   |                     |  |                      |                                 |   |                              |                     | -                               |
| × 68           | requires that the death certifications is signed by the attending posterior be detached for use as   | Physician/M  | 23b. Was decedent pregnant in the past 12 months?                               | 23c. If yes, outcome 1 Live B |   |                     | Ectopic pregnanc                         | v                    |                                 |   | 23d. Date                    | e of deliv          | ery                             |
| Вох            | death<br>the atte  | /sici        | 1  Yes 2 No<br>9 Unknown  |                               | ant at time of d                              |                     | Other (specify)                          | ,                    |                                 |   | Mor                          | ith                 | Day Year                        |
| Ö              | that the<br>ned by th<br>e detach  | F.           | Part II. Other significant conditions of  | ontributing to de             | ath but not resu                              | ulting in the u     | nderlying cause giv                      | en in Part I         |                                 | 220 Did to                              | hanna una nentri             | buta ta t           | ne cause of death?              |
|                | signe<br>d be o  | d by         | Prostate Cancer   |                               |   |                     | , ,                                      |                      |                                 |   |                              |                     | bably 4 Unknown                 |
| g              | law requires<br>nas been sign<br>e 2 should b  | lete         |   |                               |   |                     |  |                      | -                               | 24a. Was a                              |                              |                     | psy findings available          |
| Vital Records, | s certificate has b<br>director, page 2 s  | Completed    |   |                               |   |                     |  |                      |                                 | autops<br>perfor                        | med? p                       | rior to co<br>eath? | mpletion of cause of            |
| r<br>E         | an: The<br>tifficat<br>tor, pa   |              | 25. Was case referred to medical  | 77                            |   |                     | 26 PI                                    | ace of Deat          | th (Check o                     | 1 Yes                                   | 2 No 1                       | ☐ Yes               | 2 No                            |
| \ \frac{1}{2}  | ysicik<br>is cer<br>direc  | To B         | examiner?<br>1 🗌 Yes 2 🗷 No   | Hospital:                     | patient 2 🗆 I                                 | ER/Outpatien        | Oth                                      |                      |                                 | ,,                                      | ence 6 Othe                  | (Specifi            | Assisted                        |
| 0              | ng Ph<br>ter thi   |              | 27. Manner of Death 1 ■ Natural 5 □ Pending                                     | 28a. Date of                  |   | 28b. Time of injury | 28c. Injury<br>work                      | / at                 |                                 |   | w injury occurre             |                     | Living                          |
| 0              | eath.<br>eath.<br>or: Af<br>the fu   | tica         | 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b            |                               | , 22), 132.7                                  |                     | M 1 🗆                                    | Yes 2                | No                              |   |                              |                     |                                 |
| Division of    | or Atl   | Certificate: | 4 Homicide determined   | 28e. Place o                  | f Injury - At hor<br>g, etc. <i>(Specify)</i> | me, farm, stre      | et, factory, office                      |                      | 28                              | f. Location (St<br>City or Town         | reet and Number<br>n, State) | r or Rurai          | Route Number,                   |
| ָב ב           | ours a ours a crail [  |              | 29a. Certifier 1 Certifying Phys  | rigians To the her            | at of my knowle                               |                     |  |                      |                                 |   |                              |                     |                                 |
| :              | on the Hospital or Attending Physician: within 24 hours after death. To the Euneral Director. After this certification properties of the funeral director, completely filled in by the funeral director, | Medical      |   | ner: On the basis             | of examination                                | and/or investi      | gation, in my opinio                     | n, death oc          | curred at the                   | e time, date an                         | d place, and due             | to the car          | use(s) and manner stated.       |
|                | To To T  |              | 29b. Signature and title of certifier   | 0 0                           | mp  |                     | 29c, License                             |                      |                                 |   | 9d. Date signed              | _                   |                                 |
|                | ,  |              | Valent HZ   | nand                          |   |                     |  | D0055                | 5522                            |   | April 2                      | 3, 2                | 012                             |
|                | $\mathcal{C}_{x_{f}}$  |              | 30. Name and address of person who o  |                               |   |                     | ,  |                      |                                 |   |                              |                     |                                 |
|                | Stat   | 9            | Robert H. Gera 31. Date filed (Month, Day, Year)                                | 32. Re                        | 1500 I<br>gistrar's Signatu                   |                     |  | ad, Si               | ilver                           | Spring                                  | , Maryl                      | and_                | 20910                           |
|                | Registra   | _            | APR 242   | 012                           | HELL  | p. 4                | harry                                    |                      |                                 |   |                              |                     |                                 |

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

|  |                             |  | Pleas                   | se Type or                                   |                           |                     |   | <b>k. Ensure</b> <i>I</i><br>Health and I | -                             |            | _                        | le.          |                               |                      |
|--|-----------------------------|--|-------------------------|--|---------------------------|---------------------|---|---|-------------------------------|------------|--------------------------|--------------|-------------------------------|----------------------|
|  |                             | For<br>State<br>Registrar  |                         | State of                                     | iviaryiari                | •                   | rtificate of l  |   | vientai my                    | 0          | 20                       | 12           | 11                            | 192                  |
| D  |                             | Decedent's Nam   | e (First, Middle,       | Last)  |                           |                     |   |   | 2. Date of De                 |            |                          | , 5          | 3. Time of                    | f Death              |
| Physicia<br>Medic  |                             |  |                         | d Carroll                                    | _                         |                     |   |   | April                         | 23         | 201                      | 2 ar         | 1:35                          | A M                  |
| Examin   | er                          |  |                         | give street and numb                         |                           |                     |   | r Location of Death                       | 1                             |            | County of D              |              |                               |                      |
| Funeral  |                             | 5. Social Security N   | umber                   |  | Home<br>'. Age (In yrs. I | ast birthday)       | Charlott If Under 1 Year  | If Under 24 Hrs.                          | 8. Date of Bi                 | rth        | g.                       |              | ace (State o                  | or Foreign           |
| Director   |                             | 213-22-0   |                         | 1 <b>X</b> M 2 □ F                           | 84                        | Yrs.                | Months Days   | Hours Min.                                | 03/20/                        | 1928       |                          | Countr       |                               |                      |
| and<br>show<br>at  | 'n                          | Usual Residence of<br>10a. State                                   | 10b. County             |  | 10c. Cit                  | ty, Town or Lo      | cation  |   |                               |            |                          | 10           | d. Inside Ci                  | ity Limits           |
| Maryla<br>28a-f  | irect                       | MD   | St. Ma                  | arv's  | St                        | . Inig              | roes  |   |                               |            |                          |              | 1 🙀 Yes                       | 2 🗆 No               |
| th the   | Funeral Director            | 10e. Street and Nur  | mber                    | •  | •                         |                     | 10f. Zip Code   |   |                               | _          | izen of Wha              | t Countr     | у?                            |                      |
| ath wi   | nue                         | 47990 Be   | eachvil                 | Le Road<br>12. Was Deced                     | ent Ever in LLS           | S 13 1              | 20684   | lispanic Origin? (Sp                      | pecify Ves or No.             | USA        |                          | A            | - 111                         |                      |
| ter de<br>, or ite   | by F                        | 1 Never Marr   | ied 2 Marri             | Armed Ford                                   | es?<br>2 🗌 No             |                     | f Yes, specify Cuba   | an, Mexican, Puerto                       |                               |            | 14. Race - A<br>Black, V | Vhite, et    | C.                            |                      |
| ours at  | sted                        | 3 Widowed  |                         | If Yes, Give<br>Year or Dat                  |                           |                     | 1 ☐ Yes 2 🛣 No  |   |                               |            | Specify: I               | <u></u>      | к<br>                         |                      |
| an "na<br>Medic  | Completed                   |  |                         | t grade completed)                           |                           | (Give               | dent's Usual Occup<br>kind of work done (<br>O NOT use retired) | during most of worl                       | king                          | 16b. Ki    | ind of Busin             | ess Indu     | ıstry                         |                      |
| withir   |                             | Elementary/Sec   | onday (0-12)            | College (1-4                                 | or 5+)                    | Mecha               | nic/Roo   | fer                                       |                               | U.         | S. Gov                   | vern         | ment                          |                      |
| ntal Hy<br>ed otl  | To Be                       | 17. Father's Name (  |                         | ust)   |                           |                     |   | 18. Mother's Nan                          |                               | , Maiden S | Surname)                 |              |                               |                      |
| ould b   |                             | George (   |                         | p (Type, Print)                              | -                         | 19h Mailir          | na Address (Street  | Anna Bu<br>and Number or Rui              |                               | or City or | Town State               | Zin Cr       | nda)                          |                      |
| id 2 shealth a   |                             | Mary Car   |                         |  |                           |                     |   | lle Rd. S                                 |                               |            |                          |              | ue)                           |                      |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.   |                             | 20a. Method of Disp  |                         | 3 🗌 Removal from S                           |                           |                     | osition (Name of<br>matory or other place                       | ce)                                       | Date                          | 20c. Lo    | ocation - City           | y or Tow     | n, State                      |                      |
| artmen<br>ortant:  |                             |  | 5 Other (Sp             |  | MD                        |                     |   | ery 04/27                                 |                               |            | tenhar                   |              |                               |                      |
| permir<br>Depar<br>Impol<br>any ir   |                             | 21. Signature of Fu  | luci service Li         | Mil  |                           |                     |   | tt Way Me                                 |                               |            |                          |              |                               |                      |
|  |                             | 23a. Part 1. Enter t<br>shock, or hea                              | the disease, or o       | complications that can                       | n line.                   |                     |   |   | or respiratory a              | rrest,     |                          |              | Approximat<br>Interval Bet    |                      |
| Physician/   |                             | Immediate Cause (  |                         | a  | P                         | enu                 | white   |   |                               |            |                          |              | Onset and I                   |                      |
| Medical<br>Examiner  |                             | resulting in death)  | 1                       | Due to (o                                    | r as a consequ            | uence of):          |   |   |                               |            |                          | 7            |                               |                      |
|  | iner                        | Sequentially list co<br>if any, leading to in<br>cause. Enter Unde | nditions,<br>nmediate   | b. Due to (o                                 | r as a consequ            | uence of):          |   |   |                               |            |                          | +            |                               |                      |
| cuted<br>and<br>transit  | Examiner                    | Cause (Disease or<br>that initiated event                          | iinjury<br>s            | C  |                           |                     |   |   |                               |            |                          | $\bot$       |                               |                      |
| be executed<br>sician and<br>burial-transit  | calE                        | resulting in death)  | Last                    |  | r as a consequ            | uence ot):          |   |   |                               |            |                          |              |                               |                      |
| eath certificate b<br>attending physic<br>for use as the b   | /ledi                       |  |                         | d  |                           | -                   |   |   |                               |            |                          | _            |                               |                      |
| h certi<br>tendin<br>r use a   | ian/                        | IF FEMALE:<br>23b. Was decedent<br>in the past 12                  | pregnant                | 23c. If yes, outc                            | ome of pregna             | ancy<br>aldeath 3 [ | Ectopic pregnanc  | су  |                               |            | 23d. Date of             |              | •                             |                      |
| e deat<br>the at<br>thed fo  | ysic                        | 1 Yes 2 9 Unknown  | □ No                    | 4 ☐ Pregna<br>g ☐ Unkno                      | ant at time of o          | death 5             | Other (specify)   |   |                               |            | Month                    |              | Day \                         | Year                 |
| requires that the de<br>been signed by the<br>should be detached   | Completed by Physician/Medi | Part II. Other signif  | ficant condition        | ns contributing to de                        | ath but not res           | sulting in the u    | ınderlying cause gi   | ven in Part I.                            | 23e. Did                      | tobacco u  | se contribut             | e to the     | cause of d                    | leath?               |
| quires<br>en sign<br>ould be   | ted k                       | Ful  | non                     | my Hy  | pro                       | eres                | 050   |   | 1 🗆                           | Yes 2      | □ No 3 □                 | ] Proba      | ably 4                        | Unknown              |
| law re<br>nas be<br>e 2 sho  | nple                        | fu   | Inon                    | ung !  | FDO                       | tu                  | , ,   |   | 24a. Was                      | psy        | prior                    | r to com     | sy findings a<br>pletion of c | available<br>ause of |
| n: The<br>ficate h   |                             | 25. Was case referre   | y Re I                  | T DIA  | be fee                    | me                  | Wife  |   | 1 🗆 Yes                       | ormed?     | deat                     | th?<br>Yes 2 | □ No                          |                      |
| ysicial<br>s certii<br>directo   | To Be                       | examiner?  | No No                   | Hospital:                                    | patient 2 🗆               | FB/Outpatier        | Oth   | er:                                       | ome 5 Res                     | idanaa 6   | Othor (S                 | nonifu)      |                               |                      |
| ng Phy<br>fter thi<br>ineral   |                             | 27. Manner of Death  | h<br>5 🗆 Pending        | 28a. Date o                                  |                           | 28b. Time of injury |   | y at                                      | 28d. Describe                 |            |                          | pecity)      |                               |                      |
| ttendi<br>death.<br>stor: A<br>/ the fu  | Certificate:                | 2 ☐ Accident<br>3 ☐ Suicide  | Investiga<br>6  Could n | ot be  | f Injuny - At he          | mo form etr         |   | Yes 2 No                                  | 201 1 11                      |            |                          | 5 15         |                               |                      |
| al or A<br>s after<br>I Direct<br>d in by  |                             | 4 U Homicide   | determir                | ned building                                 | g, etc. (Specify          | /)                  | eet, factory, diffice   |   | 28f. Location (<br>City or To | wn, State) |                          | 'Hural H     | oute Numb                     | er,                  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi  | Medical                     | 29a. Certifier 1<br>(Check 2                                       | Certifying I            | Physician: To the be<br>aminer: On the basis | st of my know             | ledge, death        | occured at the time   | e, date and place, a                      | nd due to the ca              | ause(s) an | d manner as              | s stated     |                               | nnar stated          |
| the Forther 2 the Forther 2 the Forther 5 th | ₩                           | only one) 3  | Certifying I            | Nurse Practioner: To                         | the best of m             | y knowledge,        | death occurred at th  | e time, date and pla                      | ice, and due to the           | he cause(s | ) and manne              | er as stat   | ed.                           | Tiller stated.       |
| 1  |                             | <b>&gt;</b> (8   | MULL                    | DI   |                           |                     |   | 37228                                     | mo                            |            | e signed (M              |              | 3, Zo                         | 012                  |
| 2021   |                             | 30. Name and addr  | ess of person w         | ho completed cause                           | of death (Item            | n 23a) (Type, F     |   | 10-1                                      |                               | -0-1       | -11                      |              | 1                             |                      |
| V  |                             | 31. Date filed (Mont   | h Day Yearl             | , on n4                                      | istrar's Cian-            | ture *              |   |   |                               |            |                          |              |                               |                      |
| Stat<br>Registra   | e<br>Ir                     | 31. Date filed (Mont   | APR 2                   | 6 2012                                       | www.                      | A. A                | back  |   |                               |            |                          |              |                               |                      |

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 492 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 29, Day 2012 Year Richard Franklin Crampton 2:38 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3651 Harpers Ferry Road Washington Sharpsburg 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours **Director** 218-24-2044 1 X M 2 D F 82 Yrs. May 3, 1929 Maryland Usual Residence of Decedent 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Washington Sharpsburg 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 3651 Harpers Ferry Road 21782 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 X Yes 2 [
If Yes, Give 0 þ 1 Never Married 2 Married 2 No 1 ☐ Yes 2 🗓 No Specify: Specify: White "natural", 3 → Widowed 4 □ Divorced Completed Year or Dates. Korea the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) 12 Work Leader Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Dermit. Page 1 and 2 should be file Department of Health and Mental | mportant: If item 27 is marked of ၉ Franklin Harvey Crampton Lottie Rebecca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 i any injury or other tra Vernon R. Crampton (Son) 19219 Old Waterford Rd. Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State View Cemetery May 2, 2012 Sharpsburg, Maryland Donation 5 Other (Specify) Signature Viruneral Service Licen 22. Name and Address of Facility Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, MD 21795 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate
Interval Between
Onset and Death
Years shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Coronary Artery Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Colon Cancer 1 Yes 2 No 3 X Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? Yes 2 No 1 Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending (Month, Day, Year) ☐ Accident☐ Suicide 1 Yes 2 No Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

Records, Hospital or Attending Physician: The law Division of Vital 24 hours after death. Funeral Director: A

P.O. Box 68760

Baltimore, Maryland 21215-0036

JW6+1 State

Registrar DHMH 17 Rev 06-2011 only one

31. Date filed (Month

29b. Signature and title of certifier

Tania Crussiah

3 Byrkit Drive Williamsport, Maryland 21795

MD.

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

April 30, 2012

D0066288

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

|  |                 | State of Maryland / Department 1-For State  |  | Reg. No. 2012 49  |  |  |  |  |  |  |  |  |  |
|--|-----------------|---|--|---|--|--|--|--|--|--|--|--|--|
| hysicia<br>Exami   | an/<br>iner     | 1. Decedent's Name (First, Middle,Last) Oscar Arnulfo Chavez  |  | 2. Date of Death Month Day April 24, 2012  3. Time of Death 1110 hrs  |  |  |  |  |  |  |  |  |  |
|  |                 | 4a. Facility Name (if not institution, give street and number)  | 4b. City, Town, or Location of Death   | April 24, 2012  |  |  |  |  |  |  |  |  |  |
|  |                 | 722 Shelby Drive  | Oxon Hill  | Prince George's   |  |  |  |  |  |  |  |  |  |
| ineral<br>rector   |                 |   | If Under 1 Year If Under 24Hrs Months Days Hours Min                                 | 16  |  |  |  |  |  |  |  |  |  |
| any  |                 | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo   | cation   | 10d. Inside City Li   |  |  |  |  |  |  |  |  |  |
|  | _               | MD PG Oxon Hil  |  | 1 X Yes 2   |  |  |  |  |  |  |  |  |  |
| 28a-f show<br>d at once.   | cto             | 10e. Street and Number  | 10f. Zip Code  | 10g. Citizen of What Country?   |  |  |  |  |  |  |  |  |  |
| ns 23a or 28a-f sho<br>be notified at once.  | Director        | 722 Shelby DR.  | 22045  | EL Salvador   |  |  |  |  |  |  |  |  |  |
| Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho<br>injury or other traumatic event, the Medical Examiner must be notified at once. | Funeral         |   | Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puerto           |   |  |  |  |  |  |  |  |  |  |
| ural", o<br>miner n  | by              | 3 Widowed 4 Divorced If Yes, Give Year or Dates:  | Yes 2 No specify:  | Specify: White  |  |  |  |  |  |  |  |  |  |
| o "nati  | Completed       |   | nent's usual Occupation (Give kind of vigority) most of working life. DO NOT use ret |   |  |  |  |  |  |  |  |  |  |
| er tha   | m D             | 6th Cons  | truction   | Construction  |  |  |  |  |  |  |  |  |  |
| d oth  |                 | 17. Father's Name (First, Middle, Last)   | 18.Mother's Name   | e (First, Middle, Maiden Surname)   |  |  |  |  |  |  |  |  |  |
| vlenta<br>narke<br>event   | To Be           | Raul Chavez  19a. Informant's Name/Relationship (Type, Print )  19b. Mai  | Ana Cel  | ia Manzanares Rural Route Number, City or Town, State, Zip Code)  |  |  |  |  |  |  |  |  |  |
| 27 is n  | 1-              |   |  | Arlington VA, 22201   |  |  |  |  |  |  |  |  |  |
| item item  |                 | 20a. Method of Disposition 20b. Place of Disposition  | position (Name of cemetery,  | Date 20c. Location - City or Town, State  |  |  |  |  |  |  |  |  |  |
| nt of<br>it: If  |                 | 1 🔀 Burial 2 Cremation 3 Removal from State crematory or  |  | 0/2012 71 7-1   |  |  |  |  |  |  |  |  |  |
| artme<br>sortan  |                 | 4 Donation 5 Other Specify: Family Cemetery 5/8/2012 El Sal 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W.H.Bacon F.H.   |  |   |  |  |  |  |  |  |  |  |  |
| E E G  |                 | 1/2 1/2 // // // 0000000  | 8447 14th ST. N  |   |  |  |  |  |  |  |  |  |  |
| ician  |                 | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter<br>failure. List only one cause on each line.  | er the mode of dying, such as cardiac of   | or respiratory arrest, shock, or heart  Approximate Inte  |  |  |  |  |  |  |  |  |  |
| edical<br>niner  |                 | Immediate Cause (Final disease a Carbon Monoxide Toxicity   |  | Death   |  |  |  |  |  |  |  |  |  |
|  |                 | or condition resulting in death)  Due to (or as a consequence of):  |  |   |  |  |  |  |  |  |  |  |  |
|  | <u>.</u>        | Sequentially list conditions, if any, leading to immediate of the conditions of the |  |   |  |  |  |  |  |  |  |  |  |
|  | Ë               | cause. Enter Underlying Cause (Disease or injury that initiated   |  |   |  |  |  |  |  |  |  |  |  |
| nsit   | Examine         | events resulting in death) Last Due to (or as a consequence of):  |  |   |  |  |  |  |  |  |  |  |  |
| ysician and<br>burial - transit  |                 | d. UNPENDED AMENDED   |  | · · · · · · · · · · · · · · · · · · ·   |  |  |  |  |  |  |  |  |  |
| ysician<br>burial  | <b>f</b> edical |   |  | Logi paratura   |  |  |  |  |  |  |  |  |  |
| e attending phy<br>for use as the  |                 | 23b Was decedent pregnant in the  | Fetal death 3 Ectopic pregna   | 23d. Date of delivery  Month Day Year   |  |  |  |  |  |  |  |  |  |
| ned by the<br>detached   |                 | Part II. Other significant conditions contributing to death but not resulting in the  | e underlying cause given in Part I.  | 23e. Did tobacco use contribute to the cause of death?  |  |  |  |  |  |  |  |  |  |
| signe<br>d be de   | ğ<br>b          |   |  | 1 Yes 2 No 3 Probably 4 Unknow  |  |  |  |  |  |  |  |  |  |
| s been<br>should   | Completed       |   |  | 24a. Was an 24b. Were autopsy findings available prior to completion of cause   |  |  |  |  |  |  |  |  |  |
| ate ha   | E               |   |  | performed? death?  1 Yes 2 No 1 Yes 2 No  |  |  |  |  |  |  |  |  |  |
| certificate<br>ector, page   | BeC             | 25. Was case referred to medical 25. Place of Death (Check only one)  |  |   |  |  |  |  |  |  |  |  |  |
| this<br>I dir  | 2               | 1 ✓ Yes 2 No Inpatient 2 ER/Outpatie  | ent 3 DOA Other Nursin   | ng Home 5 Residence 6 🗸 Other: Scene  |  |  |  |  |  |  |  |  |  |
| r death. rector: After by the funera   |                 | 27. Manner of Death  1 Natural 5 Pending FOUND: 28a. Date of Injury FOUND: FOUND: Apr 24, 2012 28b. Time FOUND: FOUND: 1003 hrs   | of Injury 28c. Injury at Work?  1 Yes 2 No   | 28d. Describe how injury occurred Exposure to home furnace exhaust  |  |  |  |  |  |  |  |  |  |
| 를 <b>급</b> 를   | Certification:  | 3 Suicide 6 Could not be determined (Specify) Single Family Home  |  | <ol> <li>Location (Street and Number or Rural Route Number, or Town, State)</li> <li>Shelby Drive, Oxon Hill, MD</li> </ol> |  |  |  |  |  |  |  |  |  |
| te F 24  |                 | 29a Certifier 1 CertifyIng Physician: To the best of my knowledge, death oc   |  |   |  |  |  |  |  |  |  |  |  |
| within 24 h  To the Fuc  | Medical         | one) 2 Medical Examiner: On the basis of examination and/or investi<br>and manner stated.   | gation, in my opinion, death occurred a  | at the time, date and place, and due to the cause(s)  |  |  |  |  |  |  |  |  |  |
|  | ž               | 29b. Signature and title of certifier   | 29c. License number  | 29d. Date signed (Month, Day, Year)   |  |  |  |  |  |  |  |  |  |
| 1 6  |                 | Carol Hallan  | O.C.M.E.   | April 25, 2012  |  |  |  |  |  |  |  |  |  |
| 4  | ı               | Name and address of person who completed cause of death (Item 23a)     Carol Allan, MD  |  | 5.01000   |  |  |  |  |  |  |  |  |  |
| $A$ , $\Gamma$   |                 | Carol Allan, MD Assistant Medical Examiner 900 W. B   |  |   |  |  |  |  |  |  |  |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Spnia Maribel Leiva  |  | Stat<br>end#19a   |  |                 |                             | f Health and<br>f Death                        | d Mental F                            | lygiene                            | Reg. No                 | 20   | 12             | 1492                                     |
|--|--|---|--|-----------------|-----------------------------|--|---------------------------------------|------------------------------------|-------------------------|--|----------------|--|
| Physician/<br>Medical Examine  | 1. Decedent's N  | <sub>ame (First, Middle,L</sub><br>Maribel  |  | havez!          |                             |  |                                       | 2. Date of D<br>Month<br>April 24, |                         | Year                                       |                | of Death<br>0 hrs                        |
|  | 4a. Facility Nam<br>722 Shell  | e (ii not institution, ț  | give street and nu                         | mber)           |                             | 4b. City, Town, or L<br>Oxon Hill              | ocation of Deat                       |                                    | 4                       | c. County of De<br>Prince Ged              |                |  |
| Funeral<br>Director  | 5. Social Securi 225 – 8   |   | Sex M 2XF                                  | 7. Age (In yrs. | last birthday)<br>Yrs       | If Under 1 Year Months Days                    | If Under 24Hr<br>Hours Min            | _                                  | •                       | 9.54                                       | reign La       | State or<br>I<br>bertac                  |
| w any  | Usual Residence<br>10a. State  | e of Decedent<br>10b. County  |  | 10c. City       | y, Town or Locat            | ion  |                                       |                                    |                         |  | 10d. Ins       | side City Limits                         |
| the Maryland a or 28a-f sho tiffed at once. Director   | MD<br>10e. Street and  | PG<br>Number  |  |                 | Oxon H                      | ill<br>10f. Zip Code                           | · · · · · · · · · · · · · · · · · · · |                                    | 10g. Cit                | tizen of What C                            |                | Yes 2 No                                 |
| with the M<br>is 23a or ;<br>e notified<br>ral Dir   | 722 SI   | nelby DR  |  | edent Ever in l | J.S. 13. Wa                 | 20745  | panic Origin? ( S                     | Specify Yes or I                   |                         | Salva<br>14. Race - Ar                     |                | ın, Black,                               |
| Le hours after death with the Maryland "natural", or items 23a or 28a-f show Examiner must be notified at once.  | 3 Widowed  | -   | 1 Yes<br>ed If Yes, Give Year<br>or Dates: | 2 X No          |                             | es, specify Cuban, Yes 2 No                    |                                       | o Rican, etc.)                     |                         | White, etc                                 | Whit           | e  |
| more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director  | 15. Decedent's Elementary/S 6TH  | Education (Specify econdary (0-12)  | only highest grad<br>College (1            |                 | during m                    | t's Usual Dccupation ost of working life.      |                                       |                                    |                         | Kind of Busine                             |                |  |
| MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medical To Be Compile  |  | ne (First, Middle, La<br><b>ro</b><br>Lo  |  | Ceiva           | Baker                       |  | 8.Mother's Nam                        |                                    | , Maiden                |  | Stor           | e  |
| MD 21. 12 should b. 127 is mar umatic ev.  | 19a. Informant's   | Name/Relationship   | (Type, Print)                              |                 |                             | Address (Street  N. Wayne ition (Name of cem   | and Number or                         | Rural Route N                      | umber, C                | City or Town, St                           |                | •  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 77 Department of Health and Memal Hygiene Important: If item 27 is marked other than injury or other traumatite event, the Medical To Be Comple  |  | Disposition  2 Cremation  5 Other Speci   |  | om State        | crematory or oth<br>amily ( | <sup>ner place)</sup><br>Cemetery              | y 5/8                                 | 3/2012                             | E                       | l Salv                                     |                | ate                                      |
| Balti<br>permit.<br>Departur<br>Importa  | 21 Signature of  | Funeral Service Lic   | Secon-                                     | CC036           | 34                          | lame and Address                               | of Facility W . 1                     | H. Bac<br>W. WA                    | on<br>DC                | F.H.<br>20010                              |                |  |
| Physician<br>/Medical<br>Examiner  | failure. List  | - 1   |  | noxide Toxi     | icity                       | ne mode of dying, s                            | such as cardiac                       | or respiratory a                   | arrest, sh              | ock, or heart                              |                | ximate Interval<br>en Onset and<br>Death |
| ner  | Sequentially list if any, leading to   | immediate   | b. Due to (or as a                         |                 |                             |  |                                       |                                    |                         |  |                |  |
| ited<br>d<br>ansit<br><b>Examine</b>   | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  |   |  |                 |                             |  |                                       |                                    |                         |  |                |  |
| 50, te be executed sysician and burial - transit   | UNPEND   | ED [  |  |                 |                             | 27 5-17-1                                      | 2 vt                                  |                                    |                         |  |                |  |
| the death certificate the death certificate by the attending phy ched for use as the Physician/Me  | IF FEMALE:<br>23b. Was deceded<br>past 12 mor  | Was decedent pregnant in the a late Live birth 2 Fetal death 3 Ectopic pregnancy Month Day bast 12 months?  4 Pregnant at time of death 5 Other (Specify) |  |                 |                             |  |                                       |                                    |                         |  | -              | Year                                     |
| , P.O. Bares that the de signed by the be detached for de |  |   |  |                 |                             |  |                                       |                                    |                         |  |                |  |
| cords law requi  |  |   |  |                 |                             |  |                                       | per                                | s an<br>opsy<br>formed? | prior death                                | to completion? | dings available n of cause of            |
| ital Recition: The certificate rector, page  | 25. Was case re examiner?  | ferred to medical   | [Hospital: 1                               |                 | 1                           |  | of Death (Check                       | only one)                          |                         |  |                |  |
| ion of Vi<br>tending Physi<br>eath.<br>ior: After this<br>the funeral dir<br>ation: To   | 1 V Yes 2 No 1 Indiana 2 Errorupation 3 DOA 4 Indiana 1  |   |  |                 |                             |  |                                       |                                    | e how inj               | ence 6 🗹 Ot<br>ury occurred<br>e furnace 6 |                |  |
| Division o  Hospital or Attending, 24 hours after death Runeral Director: After trely filled in by the funeral Certification:  | Apr 24, 2012 1003 hrs 28c. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  Apr 24, 2012 1003 hrs 28c. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  Apr 24, 2012 2013 hrs 28c. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  Apr 24, 2012 1003 hrs 28c. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  Apr 24, 2012 2013 hrs 28c. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  Apr 24, 2012 2013 hrs 28c. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  Apr 24, 2012 2013 hrs 28c. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) |   |  |                 |                             |  |                                       |                                    |                         | Number, City                               |                |  |
| To the Hosp<br>within 24 ho<br>To the Fune<br>completely fi  | (Check only 1 one) 2   | ✓ Medical Examin  |  | f examination   |                             | red at the time, date<br>ion, in my opinion, e | death occurred                        |                                    | te and pla              | ace, and due to                            | the cause(s    |  |
|  | 29b. Signature a   | nd title of certifier   | face                                       | an              |                             | 29c. License<br>O.C.M                          |                                       |                                    |                         | Date signed (i                             | Month, Day, \  | 'ear)                                    |
| Yr .   | Carol Alla   |   | tant Medical E                             | Examiner        | 900 W. Balt                 | impre Street, E                                | Baltimore, N                          | ID 21223                           |                         |  |                |  |
| State<br>Registrar   |  | onth, Day, Year)  | 32. Re                                     | gistrar's Signa | arks!                       |  |                                       |                                    |                         |  |                |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14924 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Raymond Kenneth Campfield Physician/ 4 02 00 M 9013 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Prince Georges Prince Georges Hospital Center Cheverly 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 577-94-8092 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 53 (Month, Day, Year) 8 / 1 1 / 5 8 Country Director 1 XM 2 □ F DC 28a-f shov City, Town or Location Hyattsville 0a. State 10d. Inside City Limits Examiner must be notified at Director Prince Georges 1 XYes 2 No 10g. Citizen of What Country? ō 10e Street and Number 6842 Standish Dr. 105 Zin 6884 Funeral 23a ت مناهدها (real", or items "natural", or items التعسامات وبالتعسيدة التعسيم ا 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 ☐ Yes 2 ☐ No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene. 7 is marked other than "r DO NO Elementary/Secondary (0-12) College (1-4 or 5+) Auto Repair Private Industry Be 17. Father's Name (First, Middle, Last) Callie Campfield 18. Mother's Name (First, Middle, Maiden Surname)
Clarice Green ပ 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print)
Ernestine Campfield/wife 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State Zip Code) 6842 Standish Dr. Hyattsviile, MD. 20784 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) Beltsville, MD. Chesapeake Crem. 4/27/12 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee W. Wesley Chavis III Funeral Service PA 10684 Southern MD BLVD Dunkirk, MD20754 MD1388 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Ph\_sician/ Obstructive Sleep Aprica disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence oi). burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Dav 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 2 🗌 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 2 29d. Date signed (Month, Day, Year) me and address of person who completed cause of death (Item 23a) (Type, Print) Drooks 31 Date filed (Month, Day, Year)
APR 2 7 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1-State AMEND#20aper fh TT Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Clark Dash April Physician/ 2.07 pm avora Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Min. Months Days Hours 457-71-1455 **Director** 1 M 2 XF 43 Yrs. Nov 30, 1968 Texas Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** the Medical Examiner must be notified Maryland Montgomery Bethesda 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 10201 Grosvenor Place #1407 20852 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ò by 1 Yes 2X No 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify "natural", Specify: Black Completed 3 Widowed 4X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 4+Government Phlebotomist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Louis James Clark Earnestine Mills 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Nichols (Sister) 7113 Christina Lane, Garland, Texas 75043 27 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 4/27/2012 Ardent Cremation Hanover, MD of Funeral Service LL 21. Signatur 22. Name and Address of Facility Phillip A. Weatherford FS alime 2431 E Oliver Street, Baltimore MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ landiovascular Disease Athlerosleroti disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Myocard Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a consequence of): ohysician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ 3 in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: Thin 24 hours after death.

the Funeral Director; After this certifice Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 🗌 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) ō 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1. Natural 5 Pending Division 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one)

avora

Registrar

THALEN

8600 Old George

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature an

29c. License number

MD

29d. Date signed (Month, Day, Year)

2011

Registrar

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $20\overset{\text{Year}}{2}$ John A. DeVivo April 5:53 A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4445 Gregg Road Brookeville Montgomery Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Hours 021-34-7299 1 🛛 M 2 □ F 65 May 1 1946 Massachusetts Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🔀 No MD Brookeville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4445 Gregg Road 20833 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White If Yes Give 3 Divorced 4 Divorced Specify. Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mailman U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Carmela Massa Mario DeVivo Camilla Massa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole A. DeVivo / 4445 Gregg Road, Brookeville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🗷 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crem. 4/27/12 Alexandria, Virginia Signature of Furieral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home Laytonsville, Maryland P.O. Box 5038, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health an Important: If item 27 is any injury or other trau Baltimore, permit. -Physician/ Medical Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed physician Division of Vital Records, P.O. Box 68760 as the l attending nse for signed by the at Id be detached for page 2 has certificate filled in by the funeral director, within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di To the Hospital

Physician/

Medical

Director

Funeral

þ

Completed

Be

ည

Examiner

**Funeral** 

Director

ems 23a or 28a-f sh r must be notified a

, o

"natural", edical Exar

the Medical

Ith and Mental Hygien 27 is marked other the traumatic event, the

Maryland 21215-0036

|   | Immediate Cause (Final disease or condition resulting in death)  | Due to (or as a consequence of):   | Cancer              |   |                                      | Onset and Death   |  |
|---|--|--|---------------------|---|--------------------------------------|---|--|
| Completed by Physician/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | Due to (or as a consequence of):  Due to (or as a consequence of):                     |                     |   |                                      |   |  |
| hysician/Med                            | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  |  | n 2                 |   |                                      | ivery<br>Day Year   |  |
| ted by Pl                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use  1  |  |                     |   | se contribute to the cause of death? |   |  |
| Comple                                  | autopsy prior to performed? death  |  |                     |   |                                      | opsy findings available<br>completion of cause of<br>2   No |  |
| Be                                      | 25. Was case referred to medical examiner?   | saminer? 26. Flace of Death (Check only one)   |                     |   |                                      |   |  |
| 우                                       | 1 Inpatient 2 ER/Outpatient 3 DOA Chief 4 Nursing Home 5 Re  |  |                     |   |                                      | sidence 6 Other (Specify)                                   |  |
| ficate                                  | 27. Manner of Death  1 Natural 5 Pending 2/ Accident Investigation 3 Suicide 6 Could not be  | 28a. Date of injury<br>(Month, Day, Year) 28b. Time of<br>injury M                     | work?               | 28d. Describe how injury occurred   |                                      |   |  |
| II Certi                                | 4 ☐ Homicide determined  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |                     | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |                                      |   |  |
| Medical Certificate:                    | 29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                     |   |                                      |   |  |
| _                                       | 29b. Signature and title of certifier  |  | 29c. License number | 29d. Date signed (Month, Day, Year)   |                                      |   |  |
|   | Banal a  | 10.00  | 770505              | \\ \L   | nil 2                                | 3 2012  |  |

Glan Burnie

MD. 21061

State Registrar 305

32. Registrar's Signature

Hospital

Name and address of person who completed cause of death (Item 23a) (Type, Print)

dhishN 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jacob Kenneth Diggs Apri1 2012 0753 A<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 075 Shady Grove Adventist Hospital Montgomery Rockville Social Security Number 8. Date of Birth

(Month, Day, Year)

Dec. 25, 1932 If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Hours Maryland 215-30-3439 79 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Marvland Washington Hagerstown ō 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 312 Key West Drive 21740 <u>United States</u> death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1953—
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. P. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced Year or Dates White injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Accountant Computers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William L. Diggs Marguerite J. Karn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.e</u> permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 26021 Ridge Manor Drive, Damascus, Maryland 20872 Barbara J. May, Daughter Baltimore, JACOB 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 04/26/2012 | Mount Airy, Maryland Grove Cemetery 21. Signature of Juneral Service Lice 22. Name and Address of Facility Molesworth-Williams, P.A., Funeral Home M01393 26401 Ridge Road, Damascus, Maryland 20872 23a. Fart 1. Enter the disease, or connock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiopulmonary Arrest disease or condition resulting in death) Medical (or as a conse pence of) Examiner arre Coronary Artery Disease Securitary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami -transit Diabetes Mellitus that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Hypertension P.O. Box 68760 23c. If yes, outcome of preg*n*ancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be director 26. Place of Death (Check only one) Other: 1 Tes 2 🛛 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed/(Month, Day, Year) 1030 ) O ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad-Mary land 20850 Medical center prise ,00 focinille 9901 Julie Dann 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARY E. DEMBY APA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BELOIR Hartord Heath and Rehabilitation Contr 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months 220-12-4853 1 □ M 2 🏋 F 93 Hours Min FEB 22, 1919 **Director** MARYLAND Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits the Medical Examiner must be notified at Director MARYLAND 1 🗌 Yes 2 🏋 No HARFORD CHURCHVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 200 ASBURY ROAD 21028 UNITED STATES or items hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2X No Specify: If Yes, Give Specify: BLACK 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) CUSTODIAN 12 PUBLIC SCHOOLS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANDREW H. HENSON, SR. MARIE BRISCOE other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shand Department of Health an Important: If item 27 is RALPH DEMBY / SON 200 ASBURY ROAD, CHURCHVILLE, MARYLAND 21028 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🎇 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or MT ZION METHODIST CEM: 04/30/12 JOPPA, MARYLAND Signature of Funeral Service Licensee e and Address of Facility
SA SCOTT FUNERAL HOME,
TENTS STREET, HAVRE Scott - G 21078 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician) disease or condition resulting in death) Medical a consequence of Examiner Sequentially list conditions. Examine cause. Enter Underlying and -transit Cause (Disease or iinjury that initiated events resulting in death) Last nding physician a Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) \_\_\_\_ in the past 12 mg Month Day Year Pregnant at time of death Yes 2 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate Yes Division of Vital the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work?
1 \( \subseteq \text{Yes} \) 2 🗌 No thin 24 hours after death.

the Funeral Director: A
mpleted filled in by the fu Accident

3 Suicide

4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only or 3 □ 29c. License number son who completed cause of death (Item 23a) (Type, Print) State

Registrar

State Registrar

DHMH 17 Rev 06-2011

19529 Doctor's Drive, Germantown, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Vinu Ganti, M.D.

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ellis Month 4 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Ac County of Death maryland Hospital Southern PRINCE Clinton 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 215 84 **Director** 07-08-61 "natural", or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If tiena 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits per Marlbaro 1 Yes 2 No 10g, Citizen of What Country? 20112 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) dministrator Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wilhelmina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30172 Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses ٤ 23a. Part 1. Enter the disease, or co shock, or heart failure. List only cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PANCREATITIS **Physician** ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Certificate: To Be Completed by Physician/Medical Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PNEUMONIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has funeral director, page 2 autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No ER/Outpatient 3 DOA 11 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After of completely filled in by the funer 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 3 ☐ Suiciae4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title 29d. Date signed (Month, Day, Year) 4/24/2012 D0064986

Registrar

PR 2 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Hugh Fountain 29 April 201°2 2:19 a. M Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Mallard Bay Care Center Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 218-34-9131 Director 1 🙀 M 2 🗆 F 74 Nov. 4, 1937 Maryland Usual Residence of Deced 10a. State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD Dorchester Cambridge 1 X Yes 2 No 9 10e. Street and Number 10f. Zip Code rms 23a or rmust be r 10g. Citizen of What Country? Funeral 807 Maryland Avenue 21613 USA items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 1955–57 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 X Married altimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: White "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) truck driver fuel distributor of Health and Mental Hygie If item 27 is marked other ir other traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ William Snow Fountain Madaline Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Jean B. Fountain wife 807 Maryland Avenue, Cambridge, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State Department of Important: If any injury or once. Crematory of Delmarva 4/30/12 4 ☐ Donation 5 ☐ Other (Specify) Delmar. DE 22. Name and Address of Facility Thomas Funeral Home P.A. we of Funeral Service Licensee 700 Locust St., Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Melodysplastic syndrome Due to (or as a c hise vence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a consequence of Exami resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year signed by the at d be detached for 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mellitus, Cirrhosi's 1 Yes 2 Ho 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s Jas performed' certificate Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after uses...
To the Funeral Director: Afte 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

DHMH 17 Rev 06-2011

APR 3 0 2012 Registrar

31. Date filed (Month, Day,

100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nnson

|                     |  | •            | 1 - State<br>RegistralAMEND#1perM                                       | 0,5/4/12;BWW,MbC   | b C                       | ertificate of l                              | Death                       | F  | Reg. No.                   |                       |                                |
|---------------------|--|--------------|---|--|---------------------------|--|-----------------------------|--|----------------------------|-----------------------|--------------------------------|
|                     | Dhusista   |              | 1. Decedent's Name (First, Middle,                                      |  |                           | ttaroli                                      |                             | 2. Date of Dea                                   | th                         | ]                     | 3. Time of Death               |
|                     | Physicia<br>Medic  |              | <del>- JUDITH - H</del>   | FRA  | FTAROLI                   |  |                             | Month<br>APRIL                                   | 24, 201                    | Year<br>2.            | 08:20 A <sup>M</sup>           |
| المعر               | Examin   | er           | 4a. Facility Name (if not institution,                                  | ,  |                           | 4b. City, Town, o                            | r Location of Death         |  | 4c. County                 | of Death              |                                |
| عمر                 |  |              | FREDERICK MEMO  |  |                           | FREDER1                                      |                             |  | FREDE                      |                       |                                |
|                     | Funeral Director   |              | 5. Social Security Number 577–28–1413                                   |  | In yrs. last birthda      | y) If Under 1 Year<br>Months Days            | If Under 24 Hrs. Hours Min. | <ol><li>Date of Birth<br/>(Month, Day,</li></ol> |                            | 9. Birthpla           | ace (State or Foreign          |
|                     |  |              | Usual Residence of Decedent   | 1□M2ØF 92  | Yrs                       |  |                             | April 21   | 1,1920                     | V.                    | A                              |
|                     | and<br>show  | 5            | 10a. State 10b. County  | 1  | Oc. City, Town or         | Location                                     | <del> </del>                |  |                            | 100                   | d. Inside City Limits          |
|                     | faryla<br>8a-f<br>tified   | Director     | MD Frede  | rick   | Midd1                     | etown  |                             |  |                            |                       | 1 Yes 2 No                     |
|                     | or 2   | ٥            | 10e, Street and Number  |  |                           | 10f. Zip Code                                |                             |  | 10g. Citizen of V          | Vhat Countr           | y?                             |
|                     | with \$23a ust b   | Funeral      | 314 Cone Branc  | h Drive  |                           | 217  | 69                          |  | U                          | SA                    |                                |
|                     | item:  | ᇤ            | 11, Marital Status  | 12. Was Decedent Eve<br>Armed Forces?                            | er in U.S.                | 3. Was Decedent of H<br>If Yes, specify Cuba | lispanic Origin? (Spec      | cify Yes or No-                                  |                            | e - Americar          |                                |
| 36                  | ", or<br>amin  | þ            | 1 Never Married 2 Marri   | ed 1 Yes 2 No  |                           | 1 ☐ Yes 2 🏝 No                               |                             | nican, etc.)                                     | Blac                       | k, White, et<br>White | C.                             |
| 8                   | tural<br>al Ex   | ted          | 3 X Widowed 4 ☐ Divorced  | Year or Dates.   |                           |  |                             |  | Specify:                   |                       |                                |
| 5                   | be filed within 72 hours after death with the Maryland ental Hyglene. ked other than "natural", or items 23a or 28a-f sho te event, the Medical Examiner must be notified at its event, the Medical Examiner.  | Completed    | 15. Deceden<br>Specify only highes                                      | i's Education<br>it grade completed)                             | (Gi                       | cedent's Usual Occup<br>ve kind of work done | during most of workir       | ng   | 16b. Kind of Bu            | ısiness/Indu          | stry                           |
| 12                  | ithin<br>ene.<br>r thai  | Cou          | Elementary/Secondary (0-12)   | College (1-4 or 5+)  |                           | DO NOT use retired)  ypist                   |                             |  | Insu                       | rance                 |                                |
| 0                   | Hyg<br>Hyg<br>othe   | Be           | 17. Father's Name (First, Middle, La                                    | ust)   |                           | ) F = 0 0                                    | 18. Mother's Name           | (First, Middle, N                                |                            |                       | <del>-</del>                   |
| au                  | ould be filed within 72 hours after death with the Maryland id Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marke other, the Medical Examiner must be notified at   | To           | Joseph Harris   |  |                           |  | Edith Mc                    | , ,  |                            | ,                     |                                |
| Maryland 21215-0036 | nould<br>ind M<br>s ma<br>umat   |              | 19a. Informant's Name/Relationshi                                       | p (Type, Print)  | 19b. Ma                   | ailing Address (Street                       | and Number or Rural         | Route Number.                                    | City or Town. S            | tate. Zip Co          | de)                            |
|                     | d 2 salth alth a 127 i   |              | Barbara Chakali   | s/Daughter   |                           | Cone Bran                                    |                             |  |                            |                       |                                |
| e,                  | age 1 and 2 should be<br>out of Health and Ment<br>It: If item 27 is marked<br>y or other traumatic e  |              | 20a. Method of Disposition  |  | 20b. Place of Dis         | position (Name of rematory or other place    | e) April                    | ate 2.7  | 20c. Location -            | City or Tow           | n, State                       |
| Ĕ                   | Page<br>nent o<br>ant: If<br>ury or  |              | 1 ☑ Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (S <sub>k</sub>      |  |                           | coln Cemet                                   | tery April                  | 2  | Brentwo                    | od, M                 | D                              |
| Baltimore,          | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.   |              | 21. Signature of uneral Service L                                       | ensee  |                           | 22. Name and Addres                          |                             | Zumana1  | II.ama Tra                 |                       | _                              |
| m<br>—              | 88 7 6 8   |              | - Richard L   | lates  | 5                         | 00 Univers                                   | sity Blvd.                  | W., Si   | lver Sp                    | ring,                 | MD 20901                       |
|                     |  |              | 23a. Part 1. Enter the disease, or on shock, or heart failure. List or  | complications that caused the                                    | e death. Do not e         | nter the mode of dyin                        | g, such as cardiac or       | respiratory arre                                 | est,                       | 4                     | Approximate<br>nterval Between |
| - 1                 | nysician/  |              | Immediate Cause (Final disease or condition                             | Con  | 002 (10                   | hear   | 2 faci                      |  |                            |                       | Onset and Death                |
|                     | Medical<br>Examiner  |              | resulting in death)   | Due to (or as  | onsequence of):           | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,      | 114/                        | MT   |                            |                       |                                |
|                     | LAGIIIIIGI   | <u>.</u>     | Sequentially list conditions,   | b. ————  |                           |  |                             |  |                            |                       |                                |
|                     | p is A   | Examiner     | if any, leading to immediate  | Due to (or as a co   | onsequence of):           |  |                             |  |                            |                       |                                |
|                     | and trans  | xar          | Cause (Disease or injury that initiated events resulting in death) Last | c<br>Due to (or as a co  | onsequence of:            |  |                             |  |                            |                       |                                |
|                     | oe exe   | al           | resulting in death) cast  | Duc to (c) as a c.   | onsequence on.            |  |                             |  |                            |                       |                                |
| 2/60                | certificate be executed inding physician and use as the burial-transit   | Medical      |   | d  |                           |  |                             |  |                            | _                     |                                |
| S                   | sertific<br>Iding<br>Ise at  |              | IF FEMALE:<br>23b. Was decedent pregnant                                | 23c. If yes, outcome of  | pregnancy                 |  |                             |  | 224 Det                    | e of delivery         |                                |
| POX                 | atter<br>after<br>affor u  | Physician/   | in the past 12 months?  1  Yes 2 No                                     | 1 Live Birth 2 4 Pregnant at tir                                 |                           | B ☐ Ectopic pregnanc<br>□ Other (specify)    | <b>Б</b> У                  |  | Mor                        | ,                     | ay Year                        |
| n                   | the de   | hys          | 9 Unknown   | 9 🗌 Unknown  |                           |  |                             |  |                            |                       |                                |
| 7.<br>2             | requires that the death cert<br>been signed by the attendir<br>should be detached for use  | by P         | Part II. Other significant condition                                    | is contributing to death but                                     | not resulting in the      | e underlying cause giv                       | ven in Part I.              | 23e. Did tot                                     | acco use contri            | bute to the           | cause of death?                |
| Š,                  | quires<br>an sig<br>ruld b   | ed           | Copp  |  |                           |  |                             | 1 👿 Ye   | es 2 🗆 No                  | 3 Probal              | bly 4 🗌 Unknown                |
| Ö                   | w rec<br>is bee<br>2 sho   | Completed    | Han blo   | TO V PT CSS  | 1118                      |  |                             | 24a. Was ar                                      |                            |                       | y findings available           |
| ě                   | he la<br>te ha<br>bage   | mo;          | Diah  | 0 40 6   |                           |  |                             | autops<br>perforr                                | med?/ d                    | eath?                 | pletion of cause of            |
| 0                   | ian: 7   | Bec          | 25. Was case referred to medical examiner?                              |  |                           | 26. Pl                                       | ace of Death (Check         |  | Z Byr NO                   | L les Z               | DE TVO                         |
| 7                   | hysic<br>lis ce  | 2            | 1 ☐ Yes 2 ☑ No  | Hospital:<br>1 Inpatient   | 2 ER/Outpat               | ient 3 DOA Othe                              | er:<br>4  Nursing Hon       | ne 5 🗆 Reside                                    | ence 6 🗆 Othe              | r (Specify)           |                                |
| 0                   | ng Pl<br>fter th   |              | 27. Manufer of Death  1 ☑ Natural 5 ☐ Pending                           | 28a. Date of injury<br>(Month, Day, Yo                           | 28b. Time<br>'ear) injury |  |                             | 8d. Describe ho                                  | w injury occurre           | d                     |                                |
| 0                   | tendi<br>leath.<br>or: A<br>the fu   | ifica        | 2 Accident Investiga 3 Suicide 6 Could no                               | ation  |                           |  | Yes 2 No                    |  |                            |                       |                                |
| SIN .               | or At<br>after c<br>Direct<br>in by  | Certificate: | 4 Homicide determin   |  |                           | street, factory, office                      | 2                           | 8f. Location (Str<br>City or Town                | reet and Numbe<br>, State) | r or Rural Re         | oute Number,                   |
| ב                   | pital<br>ours a<br>eral t  |              | 29a. Certifier 1 Certifying I   | Physician: To the best of my                                     | r knaviladas, dast        | h aggregad at the time                       | a data and place and        | 4 -4 - 4 - 4                                     |                            |                       |                                |
|                     | To the Hospital or Attending Physician: The law requires that the death within 24 burus after death.  To the Funeral Director. After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for | Medical      | (Check A Land Medical Ex  | aminer: On the basis of exam<br>Nurse Practitioner: To the basis | nination and/or inv       | estigation, in my opinic                     | on, death occurred at t     | he time, date and                                | d place, and due           | to the cause          | e(s) and manner stated.        |
|                     | Nithin North   | 2            | 29b. Signature and title of certifier                                   | varse i ractioner. To the be                                     |                           | 29c License                                  | number                      | 2  | 9d Data signad             | Month Do              | v Voorl                        |
|                     | 10   |              |   |  |                           | Ds   | 7643                        |  | 4/24                       | 112                   |                                |
|                     |  |              | 30. Name and address of person w  | ho completed cause of deat                                       | h (Item 23a) (Type        | , Print)                                     | - +-                        |  |                            |                       | 10 MD 21702                    |
|                     |  |              |   | sheh, mp   | 650                       | Than   | as Tho                      | nson   | De Ja                      | TO Ve                 | 21702                          |
| 3                   | Stat   | ~            | 31. Date filed (Month, Day, Year)                                       | 32 Registrar's   | Signature                 |  | ,                           |  |                            |                       |                                |
|                     | Registra   | ır           | APR 262   | UIL Cereus   | B. A.                     | arte.  |                             |  |                            |                       |                                |

|  |  |                         | Flease   | State of Ma  |                |                    |                          |                      |              |                 | •                               |            | •                          | е.                         |               |
|--|--|-------------------------|--|--|----------------|--------------------|--------------------------|----------------------|--------------|-----------------|---------------------------------|------------|----------------------------|----------------------------|---------------|
|  |  |                         | For State  | State of Ma  | aryianu        |                    |                          | te of E              |              | and N           | пенцан пу                       | _          | - 201                      | 2 14                       | 934           |
|  |  |                         | Registrar  1. Decedent's Name (First, Middle, La                             | ast)   |                | Cer                | uncai                    | e or L               | Jeani        |                 | 2. Date of De                   | Reg. N     | o ·                        |                            |               |
|  | Physicia   |                         |  | elding   |                |                    |                          |                      |              |                 | Month<br>April                  |            | 2012                       | 3. Time o                  |               |
| -  | Medic<br>Examir  |                         | 4a. Facility Name (if not institution, giv                                   |  |                |                    | 4b. City                 | , Town, or           | Location of  | of Death        | MALTI                           |            | c. County of De            |                            | 0             |
| med                                      |  |                         | Brighton Gardens   | of Tuckerm   | an La          | ne                 | Ro                       | ckvil                | l1e          |                 |                                 |            | Montgo                     | merv                       |               |
|  | Funeral  |                         | F77 00 0000  |  | (In yrs. last  | birthday)          | If Unde                  | or 1 Year<br>Days    | If Under     | 24 Hrs.<br>Min. | 8. Date of Bir<br>(Month, Da    |            | 9.1                        | Birthplace (State Country) | or Foreign    |
|  | Director   |                         | 577-32-9930 Usual Residence of Decedent                                      | 1 □ M 2 □XF  | 84             | Yrs.               |                          | ,-                   |              |                 | May 18,                         |            |                            | shingtor                   | n DC          |
|  | at at  | ō                       | 10a. State 10b. County   |  | 10c. City, 7   | Town or Loc        | ation                    |                      |              |                 | nay 10,                         | 1)         | 27   114                   | 10d. Inside C              |               |
|  | Aaryla<br>Ba-f s<br>tified   | ect                     | MD Montgo  | mery   | D,             | ockvi              | 110                      |                      |              |                 |                                 |            |                            |                            | s 2 🖾 No      |
|  | the h  | ٥                       | 10e. Street and Number   | mery 1   |                | JCKVI.             |                          | p Code               |              |                 |                                 | 10g. C     | itizen of What             | Country?                   |               |
|  | s 23   | <b>Funeral Director</b> | 5550 Tuckerman   | Lane   |                |                    |                          | 2085                 | 52           |                 | 1                               | US         | A                          |                            |               |
|  | death<br>item  |                         | 11. Marital Status   | 12. Was Decedent Ev<br>Armed Forces?                   |                | 13. V              | Vas Dece<br>Yes, spe     | dent of His          | spanic Orig  | gin? (Spe       | cify Yes or No-<br>Rican, etc.) |            | 14. Race - Ar<br>Black, Wi | nerican Indian,            |               |
| 36                                       | after<br>II", or<br>xami   | d by                    | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced                       | 1 ☐ Yes 2X N<br>If Yes, Give                           | Vo             | - 1                |                          |                      | Specify:     |                 |                                 |            | Specify: Wh                |                            |               |
| ခု                                       | atura<br>ical E  | Completed               | 15. Decedent's   | Year or Dates. Education                               |                | 16a. Deced         | ent's Usu                | ial Occupa           | ation        |                 |                                 | 16h        | Kind of Busine             |                            |               |
| 25                                       | an "n  | Ē                       | (Specify only highest g  | rade completed) College (1-4 or 5-                     |                | (Give k            |                          | ork done d           | luring most  | t of worki      | ng                              | 100.       | Mila of Busine             | ss/illuustry               |               |
| 2  | withi  |                         | Elementary/Secondary (0-12)  | - Conega (1-4 of 54                                    | ''             | Hom                | emak                     | er                   |              |                 |                                 | 70         | wn Home                    |                            |               |
| nd                                       | filed<br>tal Hy<br>od oth  | To Be                   | 17. Father's Name (First, Middle, Last)                                      |  |                |                    |                          |                      | 18. Mothe    | er's Name       | e (First, Middle,               | Maider     | Surname)                   |                            |               |
| <del>Z</del>                             | Ild be<br>narke  | -                       | Charles L. Smith   |  |                |                    |                          |                      | A1ma         | a Gu            | thrie                           |            |                            |                            |               |
| Mai                                      | shouth and 7 is n  |                         | 19a. Informant's Name/Relationship (   |  |                |                    | -                        |                      |              |                 | l Route Numbe                   |            |                            |                            |               |
| ď.                                       | Healt<br>Healt<br>tem 2  |                         | Paula Jan Weeda, 20a. Method of Disposition                                  | Daughter   | 20h Plac       | oe of Dispos       |                          |                      | k Lai        |                 | Vest, Po                        |            | Location - City            |                            |               |
| JO<br>L                                  | age 1<br>ent of<br>nt: If ii<br>y or o   |                         | 1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec                      | Removal from State                                     | Arff           | netery crem        | atory e                  | other place<br>10na1 | e)           | May             | y 16,                           |            |                            |                            |               |
| Baltimore, Maryland 21215-0036           | permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. |                         | 21. Sign ture of Fineral Service Lie.  | 4  |                |                    | Name.a                   |                      | s of Eacilit |                 | 2012                            |            | lington                    | , VA                       |               |
| m  | Per June any   |                         | Dehard L. L  | ates   |                | 500                | anci:                    | s J.<br>ivers        | Colli        | ins ]<br>Rlvd   | Tuneral                         | Hor<br>11v | ne Inc.                    | ng. MD 2                   | 0001          |
|  |  |                         | 23a. Part 1. Enter the disease, or con<br>shock, or heart failure. List only | one cause on each line                                 | the death. I   |                    |                          |                      |              |                 |                                 |            | ar . upr.r.                | Approxima                  | te            |
|  | hysician,  | 1 (7                    | Immediate Cause (Final disease or condition                                  | Congestiv  | ve Hea         | art Fa             | ailu:                    | re                   |              |                 |                                 |            |                            | Interval Be<br>Onset and   |               |
|  | Medical<br>Examiner  |                         | resulting in death)  | Due to (or as a  | consequen      | nce of):           |                          |                      |              |                 |                                 |            |                            |                            |               |
|  | Lxammer  | -E                      | Sequentially list conditions, if any leading to immediate                    | <sub>b.</sub> Atherosc                                 | lerot:         | ic Hea             | art I                    | disea                | .se          |                 |                                 |            |                            |                            |               |
|  | <sub>R</sub> ₹2  | Examiner                | cause. Enter Underlying<br>Cause (Disease or injury                          | Oueto (orașa<br>Atrial F:                              | -              |                    | 2                        |                      |              |                 |                                 |            |                            |                            |               |
|  | be executed sician and burial-transi   | Exa                     | that initiated events<br>resulting in death) Last                            | C. Due to (or as a                                     |                |                    | .1                       | <del></del>          |              |                 |                                 |            |                            |                            |               |
| 0  | s be executed ysician and e burial-transit   | g                       |  | Parkinson  | n's            |                    |                          |                      |              |                 |                                 |            |                            |                            |               |
| 376                                      | ficate<br>g phy<br>as th   | Med                     | IS SSAAN S   |  |                | -                  |                          |                      |              |                 |                                 |            |                            |                            |               |
| œ  | n certi<br>endin<br>r use  | an/l                    | IF FEMALE:<br>23b. Was decedent pregnant                                     | 23c. If yes, outcome o                                 | of pregnanc    | y<br>leath 3.      | Ectonic                  | pregnance            | v            |                 |                                 |            | 23d. Date of               | delivery                   |               |
| BO                                       | death  | Physician/Medi          | in the past 12 months?<br>1 ☐ Yes 2XXNo<br>9 ☐ Unknown                       | 4 ☐ Pregnant at 9 ☐ Unknown                            |                |                    | Other (s                 |                      |              |                 |                                 |            | Month                      | Day                        | Year          |
| o  | requires that the death certificate<br>been signed by the attending phys<br>should be detached for use as the  | Phy                     | Part II. Other significant conditions  | contributing to death but                              | it not resulti | ing in the ur      | nderlying                | cause div            | en in Part I |                 | 220 Did to                      |            | una cantributa             | to the cause of            | do eth 2      |
| ω,<br>σ                                  | res th<br>signe<br>d be c  | d by                    |  | <b>-</b>   |                |                    |                          | oudeo g.v.           |              | •               |                                 |            |                            | Probably 4                 |               |
| ğ  | requi<br>been<br>shoul   | lete                    |  |  |                |                    |                          |                      |              |                 | 24a. Was                        |            |                            | autopsy findings           |               |
| ပ္ပ                                      | e law<br>e has<br>tge 2  | Completed               |  |  |                |                    |                          |                      |              |                 | autor                           | osy        | prior t                    | o completion of a          | cause of      |
| <u>~</u>                                 | an: Th<br>ifficate<br>for, pe  | BeC                     | 25. Was case referred to medical   |  |                |                    |                          | 26 Pla               | ice of Deat  | th (Check       | 1 Yes                           | 2 🖺 N      | 10 1 1                     | /es 2□No                   |               |
| SE SE                                    | ysicik<br>is cer<br>direc  | To B                    | examiner?<br>1  Yes 2  No  | Hospital:  | nt 2 🗆 EF      | VOutpatien         | <br>t 3 □ D              | Otho                 | r-           |                 | me 5 🗆 Resid                    | dence      | 6 ☐ Other (So              | ecify)                     |               |
| ō  | ierth<br>neral   |                         | 27. Manner of Death 1 ☒ Natural 5 ☐ Pending                                  | 28a. Date of injury<br>(Month, Day,                    | y 28           | Bb. Time of injury |                          | 28c. Injury<br>work? | at           |                 | 28d. Describe h                 |            |                            | 001197                     |               |
| io.                                      | tendir<br>leath.<br>or: Af<br>the fu   | ifica                   | 2 Accident Investigation 3 Suicide 6 Could not                               | on   |                |                    | М                        |                      | Yes 2 🗆      | No              |                                 |            |                            |                            |               |
| Division of Vital Records, P.O. Box 6876 | or Att   | Certificate:            | 4 Homicide determined  |  |                | e, farm, stre      | et, factor               | y, office            |              |                 | 28f. Location (S<br>City or Tow |            |                            | Ru <i>ral R</i> oute Numi  | ber,          |
|  | spital<br>ours<br>eral [   | cal (                   | 29a. Certifier 1 Certifying Ph   | ysician: To the best of m                              | ny knowled     | ne death o         | Courred a                | at the time          | data and     | place or        | od duo to the or                | 21120(2)   | and manner on              | ntatad                     |               |
|  | To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the   | Medical                 | (Check 2 Medical Exam  | niner: On the basis of exa<br>rse Practitioner: To the | amination ar   | nd/or investi      | gation, in               | my opinio            | n, death oc  | curred at       | the time, date a                | nd plac    | e, and due to th           | e cause(s) and ma          | anner stated. |
|  |  |                         | 29b. Signature and title of certifier  | 011  | ,              |                    |                          | c. License           |              |                 |                                 |            | ate signed (Mo             |                            |               |
|  | 10   |                         | 1/2  | Meg  | 7              |                    |                          | D53                  | 3691         |                 |                                 | A          | pril 17                    | , 2012                     |               |
|  |  |                         | 30. Name and address of person who Ajay Reddy, MD                            | completed cause of dea 3200 Tow                        | ath (Item 23   | Ba) (Type, Pr      | nint)                    | #110                 | Root         | kwi1            | la MT                           | 208        | 5.2                        |                            |               |
|  | Sta  |                         |  |  | 's Signature   | 9 - 6 -            | Contract of the Contract | # IIU 9              | , wool       | KVII.           | re, MI                          | 200.       | <u>.</u>                   | 34                         |               |
|  | Registra   | ar                      | 31. Date filed (Month, Day, Year) APR 2 6 201                                | 2  | Jugilatule     | ber                | Med !                    |                      |              |                 |                                 |            |                            |                            |               |

| 2-031/2<br> <br> Carona Eitzpatri  | ok.            | Please Type or Print in B  |                 |  |                          |                          | egible.   |   |
|--|----------------|--|-----------------|--|--------------------------|--------------------------|---|---|
| eresa Fitzpatri  | CK             | State of Maryland  |                 | tment of He<br>ificate of De                 |                          | ntai Hygiene             | 20  | 2 1493                                    |
| Dhario   |                | Registrar  1. Decedent's Name (First, Middle,Last)   | Certi           | ilicate di De                                | taur                     | 2, Date of De            | Reg. No.  |   |
| Physici<br>Medical Exami   |                | Teresa Fit:  | znatri          | o.1r   |                          | Month                    | Day Year  | 3. Time of Death<br>0523 hrs              |
|  |                | 4a. Facility Name (if not institution, give street and number  |                 |  | ity, Town, or Location   | April 24,                | 4c. County of Dea                                   |   |
|  |                | 75 Craigtown Road  | ,               |  | ort Deposit              |                          | Cecil   |   |
| Funeral  |                | 5. Social Security Number 6. Sex 7. A  | ge (In yrs. las | t birthday) If                               | Under 1 Year If Und      | ler 24Hrs. 8. Date of E  | Birth (MM/DD/YYYY) 9. E                             |   |
| Director   |                | 221-56-0930 1 M 2XF  | 50              | Yrs.   | onths Days Hour          | s Min. March             | 1 24,1962 For                                       | eign<br>CountryDelaware                   |
|  |                | Usual Residence of Decedent  |                 |  | <del></del>              | That of                  | 21,1202   | Delawate                                  |
| any any  |                | 10a. State 10b. County   | 10c. City, To   | own or Location                              |                          |                          |   | 10d. Inside City Limits                   |
| and<br>show  | -0             | Maryland Cecil   |                 | I  | ort Depos                | it                       |   | 1 Yes 2 X No                              |
| Maryl<br>28a-  | Director       | 10e. Street and Number   |                 | 10f  | Zip Code                 |                          | 10g. Citizen of What Co                             | ountry?                                   |
| r death with the Maryland<br>or items 23a or 28a-f sho<br>must be notified at once,  |                | 75 Craigtown Road  |                 |  | 21904                    |                          | U.S.A   |   |
| h witi   | Funeral        | 11. Marital Status  1 Never Married 2 Married Armed Forces   |                 |  | edent of Hispanic Ori    | igin? (Specify Yes or N  | lo- 14. Race - Am<br>White, etc.                    | erican Indian, Black,                     |
| r deat   | Fur            | 1 Yes 2  | X No            |  |                          |                          |   |   |
| s afte   | by             | 3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade co  | mploted) 1      |  | 2 X No specify           |                          | Specify:<br>16b. Kind of Busines                    | White                                     |
| hour "nath   | ted            | Elementary/Secondary (0-12) College (1-4 or  |                 |  | working life. DO NOT     |                          | Tob. Kind of Busines                                | s/industry                                |
| hin 7.<br>than<br>edical   | ple            | Twelve Years   | - /             | H  | omemaker                 |                          | Personal  | Residence                                 |
| 5-003<br>iled withi<br>Hygiene.<br>I other ti  | Completed      | 17. Father's Name (First, Middle, Last)  |                 |  |                          | r's Name (First, Middle  |   | 11001401160                               |
| is the first of th | Be             | Ted Drummond   |                 |  |                          | Betty                    | Jo Ward   |   |
| Z = 2 = 3  | ျှ             | 19a. Informant's Name/Relationship (Type, Print )  |                 |  | •                        |                          | umber, City or Town, Sta                            |   |
| and 2 shou fealth and I traumatic  |                | Nicole Drummond (Daugh   |                 |  |                          |                          | tta, Georgi   |   |
| re, M<br>s l and 2<br>f Health<br>if item 2  |                | 20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from S  |                 | ace of Disposition of<br>ematory or other pl | Name of cemetery, ace)   | Date                     | 20c. Location - City of                             | or Town, State                            |
| Page<br>Page<br>nent o   |                | 4 Donation 5 Other Specify:  | Pri             | incipio C                                    | emetery                  | 05/01/12                 | Perryville  | e, Maryland                               |
| Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other the  |                | 21. Signature of Funeral Service Licensee  |                 | 22. Name                                     | and Address of Facilit   | y<br>on & Son Fr         | uneral Home   | TD A                                      |
|  |                | Moman M. + Cltterao  |                 | Perr   | zville. Ma               | ryland 21                | 903-0766  |   |
| Physician<br>/Medical  |                | 23a. Part I. Enter the disease, or complications that caused<br>failure. List only one cause on each line.   | d the death, D  | o not enter the mo                           | de of dying, such as o   | cardiac or respiratory a | rrest, shock, or heart                              | Approximate Interval<br>Between Onset and |
| Examiner   |                | Immediate Cause (Final disease or condition resulting in death)  Due to (or as a cons  | rrhyth          | mia<br>Naraotia                              | Onioid (N                | lorabino VIIa            | o and   | Death                                     |
|  |                | presumed   | Gastro          | enteriti                                     | s complica               | ting Hyper               | tensive   |   |
|  | miner          | if any, leading to immediate Due to (or as a cons  | equence of):    | L Caruit                                     | Vascuiai                 | ISEASE                   |   |   |
|  | Ë              | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last  Due to (or as a cons   | equence of):    |  |                          |                          |   |   |
| xecuted<br>n and<br>- transit  | cal Exa        | events resulting in death) Last Due to (or as a cons   |                 |  |                          |                          |   | _   |
| • ਕ <b>ਕ</b>   |                | X UNPENDED AMENUE 23a  | -b,pt.          | 11,27,28                                     | a-f,per me               | ,g928 6-21               | -12 sm  |   |
| 760,<br>ficate be exe<br>g physician a   | Physician/Med  | IF FEMALE: 23c. If yes, outco  |                 |  |                          |                          | 23d. Date of delive                                 | ery                                       |
| OX 687 cath certific attending   | an/            | 23b. Was decedent pregnant in the past 12 months?  | t time of death | 2 Fetal de                                   | ,                        | c pregnancy              | Month   | Day Year                                  |
| eath c atten for us  | Sic            | 1 Yes 2 No 9 Unknown 9 Unknown   | t time of deat  | 5 Other (                                    | Specify)                 |                          | 1   |   |
| that the d   | F.             | Part II. Other significant conditions contributing to deal   | th but not resu | ulting in the underl                         | ying cause given in Pa   | art I. 23e. Did          | tobacco use contribute t                            | o the cause of death?                     |
| , P.(<br>res tha<br>signed<br>be det   | Completed by   | Diverticulitis, Diverticul   | osis.C          | hronic O                                     | bstructive               | 1 Ye                     | es 2 No 3 🗸 Pro                                     | obably 4 Unknown                          |
| rds, requirements of the control of  | ete            | Pulmonary Disease, Hyperl:   |                 |  |                          | 24a. Was                 |   | autopsy findings available                |
| e law<br>e has   | 臣              |  |                 |  | e Kenai i                | perfe                    | ormed? death?                                       |   |
| tal Recting: The certificate ector, page   |                | Hepatitis C, Chronic Bac   | k_Pain          |  | 26. Place of Death       |                          | 2 No 1 V  | Yes 2 No                                  |
| Vital hysician:<br>this certif   | o Be           | examiner?  1 Yes 2 No Hospital: 1 Inpatie  | ent 2 El        | R/Outpatient 3                               | DOA Other                | Nursing Home 5           | Residence 6 🗸 Oth                                   | er; Scene                                 |
| of 38 P  | -1             | 27. Manner of Death 28a. Date of Inj<br>(Month, Day,   | ury 2           | 8b. Time of Injury                           | 28c. Injury at Work      | ? 28d. Describe          | how injury occurred                                 |   |
| Division<br>tal or Attendii<br>rs after death.<br>al Director: A<br>led in by the fu   | 흹              | Natural 5 Pending Investigation fd 4-24  | · I             | d 5:00 an                                    | 1 Yes 2 📉                | No subject               | took drug   |   |
| ivisi<br>or Att<br>after de<br>Direct<br>in by   | iĝ.            | 3 Suicide 6 Could not be 28e. Place of Ir  |                 |  | ory, office building, et | c. 28f. Location         | (Street and Number or R<br>State) <b>75 Craig</b> ( | tural Route Number, City                  |
| Divi<br>Hospital or<br>24 hours afte<br>Funeral Directly filled in   | Certification: | 4 Homicide determined (Specify)  | Res             | idence                                       |                          | Port D                   | eposit,MD.  |   |
| Division  To the Hospital or Attenwihin 24 hours after death To the Funeral Director:  |                | 29a. Certifier (Check only one)  Certifying Physician: To the best of mone)  Certifying Physician: To the best of money definition of the basis of examiner: On the basis of examiner: |                 |  |                          |                          |   |   |
| To the within To the comple  | Medical        | and manner stated.  29b. Signature and little of certifier   | - 4             | Zà.  | 29c. License number      | and at the time, date    | 29d. Date signed (M                                 |   |
|  | -              | 6)/160//160//  | 1/ me           | 185  | O.C.M.E.                 |                          | April 24, 2012                                      | o, Day, 1 Gai /                           |
|  | ļ              | 30. Name and address of person who completed cause of  | death (Item 22  | 3a)  |                          |                          | 1   |   |
|  |                | Victor Weedn MD JD Assistant Medica  |                 | •  | Itimore Street, B        | altimore, MD 212         | 23  |   |
| St   | ate            |  | ar's Signatur   | parke  |                          |                          |   |   |
| Regist   |                | MAI 4 MINE / Sector  | w B.            | 10 to 10                                     |                          |                          |   |   |

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIL 201°2 HAROLD JOSEPH FRIEDRICHSEN 14:15PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNION HOSPITAL OF CECIL COUNTY CECIL ELKTON Social Security Number If Under 1 Year | If Under 24 Hrs. Sex 1XXM 2 □ F Age (In yrs, last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Days Hours DEC. 18. Year) Director 269-46-7335 1947MASSILLON.OHIO 64 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 V No MARYLAND CECIL NORTH EAST 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15 CEDAR ALLEY 21901 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race · American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. If Yes, Give Year or Dates WHITE Specify: Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 BRICKLAYER CONSTRUCTION Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES EDWARD FRIEDRICHSEN MARGUERITE E. PAINTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET BOMBA / SISTER PLUM CREEK ROAD, NORTH EAST, MARYLAND 21901 20b. Place of Disposition (Name of APRIL CEMETERY APPROPRIED APRIL 2012 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal for 4 Donation 5 Other (Specify) ELKTON, MARYLAND 21. Signature for Service Li 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death iver cirrolisis Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death the sate has been signed by t page 2 should be detach Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 🗌 Yes 2 🗌 No 2 No Yes 25. Was case referred to medica a 26. Place of Death (Check only one) Other: 2 🔀 No 1 Yes ျှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending n 24 hours and, he Funeral Director: Aff Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier 1🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) MD 00062190 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHN AWA2 KHAN AUGUSTINE HERMAN HWY, SVITEA, CHESAPENICE CITY 2533

State

Registrar

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 4<sup>Month</sup> Physician/  $20^{\text{Year}}$ 10:55 PM Kathryn Eppley Forwood Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2660 Tome Highway Cecil Colora Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours Min. 1 M 2 XF 716/1925 Yrs Director 189-32-1982 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner more than once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Cecil Colora 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 21917 USA 2660 Tome Highway 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Music Teacher Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Robert M. Eppley Iva M. DeVenney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Art Allen - Executor 2660 Tome Highway, Colora, MD 21917 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/23/2012 Mount Zion Cemetery Boiling Springs, PA uneral Service Licens 22. Name and Address of Facility R.T. Foard Funeral Home, PA S. Queen Street, Rising Sun, MD 21911 23a. Part 🖟 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner equer tially list conditions Examines if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). . Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 p 9 Unknown the detached 9 I Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has page 2 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury work? Natural 5 Pending after death Director: / Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of D0662190 2

DHMH 17 Rev 7/2009

State Registrar

10

HERMAN

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUGUSTINE

31. Date filed (Month, Day, Year)

SHAHNAWAZ KHAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:15 AM 39, 2012 Zelda May FIELDS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Village Hager washing ton Kavenwood Cutheran tow Birthplace (State or Foreign Country) If Under Near 7. Age (In yrs. last irthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 💢 F Director July 3 1934 Carolina N. 245-44-4849 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examinations be notified a once. 1 □Yes 2 No Director Maryland Washington Hagerstown Zelda Mae Field Itimore, Maryland 21215-0036 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 14039 Bruce Lane 21740 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🏋 No Specify. Specify: White 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 <u>Nursing Assistant</u> Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Walter Sanders Estelle Sanders 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12120 Big Pool Road, Clear Spring, Md. 21722 <u>Sharon Souders - Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 5/3/2012 Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Metastake **Physician** 10 4 200 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as this is death), act Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I autopsy perform zmeg? 2 ☑ No 2⊠No 1 □ Yes director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4-29-12

Registrar

State

368

mill stul- Hagestone 1910 21740.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ZAn

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day 1:04 JAMES ALBERT FORD JR. PRTI 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S HOSPITAL CHEVERLY 5. Social Security Number 6. Sex. 1 ZM 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 1/301/1959 217-68-6360 55 MD Director Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If ifew 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director PG 1 X Yes 2 □ No MD CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 417 70TH PLACE 20743 US 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced BLACK Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) 1 2 TH College (1-4 or 5+) FLEET MANAGER PRIVATE æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JAMES ALBERT FORD SR. SARAH LOUISE HENRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHAROD FORD/WIFE 417 70TH PLACE, CAPITOL HEIGHTS, MD 20743 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY: 4-27-12 CLINTON, MD . Signature of Funeral Servior 22. Name and Address of Facility POPE FUNERAL HOMES. P.A. 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Phylician ATAL disease or condition Medical resulting in death) Due to (or as a consequence of); **Examiner** VER Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury Metastatic COLOFGLTAL physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ☐ Yes ∠... ☐ Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has page 2 autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of completed filled in by the funeral To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 — Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 who completed cause of death (Item 23a) (Type, Print) Name and address of

State Registrar 32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Day 2012 Year Alonzo 25, Guerrero 10:29 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Days Hours 578-70-3272 Director 1 🖾 M 2 🗆 F 90 June 21, 1921 El Salvador 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 🗌 Yes 2 🔀 No P.G. Hyattsville 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 5119 Edmonston Road 20781 USA Iral", or items Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗷 Yes 2 □ No Specify Salvadorean Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Tailor Mens Clothier of Health and Mental Hygintem 27 is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Jose Roberto Flores Angel Maria Guerrero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trauonce. 9119 Redwood Avenue, Bethesda, MD 20817 Maria Taginya/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 1, 2012 1 🔀 Burial 2 🗌 Cremation 3 🗍 Removal from State Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Licensee Francis Address Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Later the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ CONGEST disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to lor as a consequence of If any hading to immediate cause. Enter Underlying attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗭 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an UERRERO GLUIS autopsy after death.

Director: After this certificate 1 ☐ Yes 2 🗀 😽 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 **Sol**io Other: 1 Yes ဂ္ 1 Population 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 1 Matural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 4/26/12 00057124

DHMH 17 Rev 06-2011

State Registrar

04 25 2012

10110 Molecular Drive, #206, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Truong Bao, MD

31. Date filed (Mont)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:51 PM Gaustad 2012 Mark G. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Ldurel Regional Hospita Laure George's Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct 21 1963 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 310-80-9855 1**XX**M 2 □ F Director Minnesota 48 28a-f shov 10c. City, Town or Loca Baltimore ural", or items 23a or 28a-f sho Examiner must be notified at Town or Location 10d. Inside City Limits Director Maryland Baltimore XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 945 Imperial Ct. 21227 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ò 1 Yes, Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced White Specify Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) warehouse technician Electrical should be filed with and Mental Hygien is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John T. Gaustad Marianne Braun permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic to 19a. Informant's Name/Relationship (Type, Print)
John Gaustad / Brother 19b Nailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), 16027 Copper Canyon Dr. Friendswood, Texas 77546 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial A Cremation 3 Removal from State Huntt Crematory or other p 4/22/2012 Waldorf, Md 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Fleck Funeral Home
7601 Sandy Spring Rd. Laurel, Md. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sclerotic Cardiovascular Disease Ph\_sician/ Arterio disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to for as a consequence of the burial-transi or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death igned by the at be detached for Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Respiratory 1 Yes 2 No 3 Probably 4 Unknown Completed should Were autopsy findings available prior to completion of cause of Chronic 24a. Was an has page 2 autopsy death? certificate Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No filled in by the Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check 3 29b. Signature and title of cert WIT 2012

Registrar

DHMH 17 Rev 06-2011

State

Laurel Bowie Road, Suite 208

Laurel, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed Sadiq,, M. D. 14333 Laurel Bov

APR 25 2012

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

|  |                     |  | Plea                                 | ase Type or                               | Print                              | in Blacl                  | k Ind         | lelible Inl                        | k. Ensure                               | All Copie                            | es Ar           | e Leg                          | jible.                   |                              |             |
|--|---------------------|--|--------------------------------------|---|------------------------------------|---------------------------|---------------|------------------------------------|---|--------------------------------------|-----------------|--------------------------------|--------------------------|------------------------------|-------------|
|  |                     | For State  |                                      | State                                     | of Mar                             |                           |               |                                    | Health and                              | Mental H                             | ygien           | e                              | 0.1.0                    |                              | 011         |
|  |                     | Registrar  1. Decedent's Name                                      | e (First, Middle                     | e. Last)                                  |                                    | (                         | Sertif        | ficate of L                        | <i>Death</i>                            | 2. Date of D                         | Reg. N          | lo.                            | Ulc                      | 4                            | 940         |
| Physicia<br>Medi   |                     |  | ( ,                                  | ERMA                                      | RF                                 | BECCA                     | G             | REEN                               |   | April                                |                 | e 2                            | 012                      | 3. Time of 5:07              | A M         |
| Examir   |                     | 4a. Facility Name (if  | not institution                      |   |                                    | DEGUIT                    |               |                                    | Location of Dea                         |                                      |                 | lc. County                     |                          | 10.07                        |             |
|  |                     | Frederi<br>5. Social Security N                                    | ck Memo                              | orial Hos                                 |                                    | yrs. last birtho          | day) If       | Freder                             | ick<br>I If Under 24 Hr                 | 2 D-44D                              | i.ab            | Fre                            | deri                     |                              |             |
| Funeral<br>Director  |                     | 218-24-7   |                                      | 1 🗆 M 2 🏲 F                               | 7. Age (II                         | . V                       |               | Ionths Days                        | Hours Min                               | . (Month, E                          | Day, Year)      |                                | 9. Birth<br>Co <i>ui</i> | place (State o<br>ntry)      | r Foreign   |
| d d  | Ļ                   | Usual Residence of   | of Decedent<br>10b. County           |   | F 10                               | 84 Town o                 |               | 00                                 |   | 02/29                                | /192            | 28                             |                          | MD                           |             |
| larylan<br><b>3a-f s</b> h<br>ified a  | Director            | MD   | ,                                    | ederick                                   |                                    | Freder:                   |               | OII                                |   |                                      |                 |                                |                          | 10d. Inside Ci<br>1 ☐ Yes    | ty Limits   |
| the Manager 28   |                     | 10e. Street and Nun  |                                      |   |                                    |                           |               | 10f. Zip Code                      |   |                                      | 10g. C          | Citizen of \                   | What Cou                 | ntry?                        |             |
| death with the Maryland<br>items 23a or 28a-f sho<br>ner must be notified at   | Funeral             | 371 W. TI  | hornhi]                              |   |                                    |                           |               | 21703                              |   |                                      |                 | USA                            |                          |                              |             |
| 2 hours after death with the Maryland<br>"natural", or items 23a or 28a-f show<br>edical Examiner must be notified at  | by Fu               | 11. Marital Status 1  Never Marri                                  | ied 2 □ Mar                          | 12. Was Dece<br>Armed Fo<br>1 ☐ Yes       | rces?                              | in U.S.                   | 13. Was       | Decedent of Hi<br>s, specify Cuba  | ispanic Origin? (S<br>ın, Mexican, Puer | Specify Yes or No<br>to Rican, etc.) | )-              |                                | e - Ameri<br>ck, White,  | can Indian,<br>etc.          |             |
| 72 hours after<br>n "natural", or<br>fledical Exami  | ted b               | 3 🖾 Widowed  | 4 Divorced                           | 16 3/ 01                                  | /e                                 |                           | 1 🗆           | Yes 2 No                           | Specify:                                |                                      |                 | Specify:                       | Bla                      | ck                           |             |
| 72 hou   | Completed           | (Spe   |                                      | nt's Education<br>est grade completed)    | )                                  | 1 (0                      | Give kind     | s Usual Occupa<br>of work done o   | ation<br>during most of wo              | orking                               | 16b.            | Kind of B                      | usiness/Ir               | dustry                       |             |
| vithin<br>jiene.<br>er thar<br>the N   |                     | Elementary/Seco  | ondary (0-12)                        | College (1                                | -4 or 5+)                          | In                        |               | OT use retired)<br>memaker         |   |                                      |                 | wn_h                           | Omo                      |                              |             |
| filed v<br>tal Hyg<br>d othe   | To Be               | 17. Father's Name (f   | , ,                                  | *   |                                    |                           |               |                                    |   | ıme (First, Middle                   |                 |                                |                          |                              |             |
| uld be<br>d Ment<br>marke<br>natic   | =                   |  |                                      | h Jackson                                 | Sr.                                |                           |               |                                    |   | Edwards                              |                 |                                |                          |                              |             |
| 2 sho Ith and 27 is r  |                     | 19a. Informant's Na  |                                      |   | 1                                  | - 1                       |               |                                    | and Number or Ri<br>• Circle            |                                      |                 |                                |                          | ,                            | 27/         |
| 1 and of Hea   |                     | 20a. Method of Disp  | position                             | nitted/dau                                |                                    | 20b. Place of E           | ispositio     |                                    |   | Date                                 |                 |                                |                          | own, State                   | 774         |
| Page<br>ment<br>tant; It   |                     | 1 L Burial 2 L<br>4 ☐ Donation                                     |                                      | 3 Removal from Specify)                   | State                              |                           |               | Mem. Ga                            |   | /21/2012                             | Fre             | ederi                          | ck.                      | MD                           |             |
| permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important If Item 27 is marked other than "natur any injury or other traumatic event, the Medical Once.   |                     | 21. Signature of Fur   | neral Service L                      | icensee                                   | 2 1                                |                           | 22. Na        | ame and Addres                     | ss of Facility St                       | tauffer                              | Fune            | eral                           | Home                     | s, P.A                       |             |
|  |                     | 23a. Part 1. Enter the   | he disease, or                       | complications that                        | caused the                         | death. Do not             | enter the     | I Oposs                            | umtown I                                | Pike, Fr                             | eder            | rick,                          | MD                       | 21702<br>Approximate         |             |
| Physician/   |                     | shock, or hear<br>Immediate Cause (I<br>disease or condition       | rt failure. <b>∖J</b> ist o<br>Final | only one cause on ea                      | ch line.                           |                           |               |                                    | eard                                    | .116                                 | ul              | 101                            | 100                      | Interval Bety<br>Onset and D | ween        |
| Medical<br>Examiner  |                     | resulting in death)  |                                      | aDue to                                   | (or as a co                        | nsequence of):            |               | 100/10                             | cova                                    | and I                                | 7               | uS                             | W                        |                              |             |
| LAdimiles  | eľ                  | Sequentially list cor  | nditions,                            | b. —                                      | Carama an                          | nisequanica orj.          |               | U                                  |   |                                      |                 |                                | - 0                      |                              |             |
| rted<br>d<br>ansit   | Examiner            | if any, leading to me<br>cause. Enter Under<br>Cause (Disease or i | injury                               | Due to                                    | or as a co                         | nsequence on.             |               |                                    |   |                                      |                 |                                |                          |                              |             |
| executed<br>ian and<br>urial-transit   | I— I                | that initiated events<br>resulting in death) L                     |                                      | Due to                                    | (or as a co                        | nsequence of):            |               |                                    |   |                                      |                 |                                |                          |                              |             |
| ath certificate be attending physici   | by Physician/Medica |  | ,                                    | d   |                                    |                           |               |                                    |   |                                      |                 |                                |                          |                              |             |
| certific<br>nding I<br>use as  | n/M                 | IF FEMALE:<br>23b. Was decedent                                    | pregnap                              | 23c. If yes, out                          | come of p                          | regnancy                  |               |                                    |   |                                      |                 | 23d Dat                        | te of deliv              | en/                          |             |
| death<br>ne atter<br>ed for  | sicia               | in the past 12 n<br>1 Yes 2  | months?                              | 1 ☐ Live<br>4 ☐ Preg<br>9 ☐ Unkr          | nant at tim                        | Fetal death<br>e of death |               | ctopic pregnancy<br>ther (specify) | y<br>                                   |                                      |                 | Mo:                            |                          | ,                            | ear/        |
| at the des<br>d by the s<br>detached   | Phy                 | 9 Unknown Part II. Other signifi                                   |                                      |   |                                    | ot resulting in t         | he unde       | rlying cause give                  | en in Part I                            | 220 Did                              | tohoooo         | Line contr                     | ibuta ta ti              | ne cause of de               | noth?       |
| requires that the street requires that the street requires that the should be determined by the street requirements that the street requirements that the street requirements that the street requirements that the street requirements that the street requirements that the street requirements that the street requirements that the street requirements that the street requirements that the street requirements that the street requirements the street requirements that the street requirements the street requirement the street requirements the street requirements the street requirements the street requirements the street requirement the street requirements the street requirements the street requirements the street requirements the street requirements the street requirements the street requirement the street requirements the street requirements the street requirements the street requirements the street requirements the street requirements the street requirements the street requirements the street requirement th |                     |  |                                      |   |                                    |                           |               | .,,g g                             |   |                                      |                 |                                |                          | bably 4 🗀 l                  |             |
| w requ<br>s beer<br>2 shou   | Completed           |  |                                      |   |                                    |                           |               |                                    |   | 24a, Was                             | s an            | 24b. V                         | Vere auto                | psy findings a               | vailable    |
| The law<br>ate has<br>page 2   | Som                 | -  |                                      |   |                                    |                           |               |                                    |   |                                      | opsy<br>formed? |                                | orior to co<br>seath?    | mpletion of ca               | luse of     |
| ician:<br>certific<br>ector,   | B B                 | 25. Was case referre examiner?                                     |                                      | Hospital:                                 |                                    |                           |               | 100                                | ace of Death (Che                       |                                      |                 |                                |                          |                              |             |
| Phys<br>r this eral dii  | e: 10               | 27. Manper of Death  | No<br>1                              | 28a. Date                                 | of injury                          | 2 ER/Outp                 |               | DOA Othe                           | 4 ☐ Nursing I                           | lome 5 Res                           |                 |                                |                          | )                            |             |
| ending<br>sath.<br>rr: Afte  | ficat               | 1 Natural 2 Accident   | 5 Pending                            | gation                                    | th, Day, Ye                        | <i>ar)</i> inju           |               | work?                              | ?<br>Yes 2 □ No                         | Zod. Describe                        | now inju        | ry occurre                     | a d                      |                              |             |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the by   | Certificate:        | 3 ☐ Suicide<br>4 ☐ Homicide  | 6 ∐ Could r<br>determi               | ined 28e. Place                           | of Injury -<br>ng, etc. <i>(S)</i> | At home, farm<br>becify)  | , street, f   | factory, office                    |   | 28f. Location (<br>City or To        |                 |                                | r or Rural               | Route Numbe                  | ər,         |
| To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b  | ledical (           | 29a. Certifier 1   | Certifying                           | Physician: To the b                       | est of mv                          | knowledge, de             | ath occu      | rred at the time                   | date and place                          | and due to the o                     | ause(s) s       | and mann                       | or as stat               | ed                           |             |
| he Ho<br>in 24 h<br>he Fui   | Med                 | (Check 2   |                                      | xaminer: On the bas<br>Nurse Practitioner | is of exami                        | ination and/or in         | ivestigati    | ion, in my opinioi                 | n, death occurred                       | at the time, date                    | and place       | <ul> <li>e. and due</li> </ul> | to the car               | use(s) and mar               | ner stated. |
| To t   |                     | 29b. Signature and t   | itle of ertifier                     |   |                                    | O 1                       |               | 29c. License                       | number                                  | ,                                    | 29d. Da         | ate signed                     | (Month,                  | Day, Year)                   |             |
|  |                     | 30. Name and addre   | 22/                                  | <b>—</b>                                  | o of do-th                         | 1 Me                      | シ<br>Dulinati | IDS                                | 20,24                                   | <u></u>                              | 4               | -16                            | 2-1                      | 7                            |             |
| Q  |                     | SAJJI  | An                                   | vho completed caus                        | - , M                              | ND.                       |               | 1 Tol                              | 1 Hous                                  | e Ave                                | F               | red                            | eric                     | h, M                         | 0           |
| Stat   | C                   | 31. Date filed (Month  | Day, Year)                           |   | egistrar's S                       | Signature                 | ho            | Mad                                |   |                                      | <del>/ '</del>  |                                |                          | 2170                         | 1           |
| Registra   | ग्र                 | P  | 11 11 6 7                            | LUIL L                                    | Market St.                         | 10.7                      | Sport works   | S. Shaker                          |   |                                      |                 |                                |                          | -                            | •           |

|  |             | 1- For State<br>Registrar  | Certificate of Death  | and Montain                                  | , 0                                       | eg. No.   |  |
|--|-------------|--|---|--|---|---|--|
| Physic<br>Medical Exam   |             | Decedent's Name (First, Middle,Last)   |   |  | 2. Date of Deat                           | h   | 3. Time of Death                                   |
| wiedicai Exam  | III(e)      | Francisco Javier Gomez-So  4a. Facility Name (if not institution, give street and number)                            |   |  | Month<br>April 24, 2                      |   | 1110 hrs   |
| 1  |             | 722 Shelby Drive   | 4b. City, Town<br>Oxon Hi   | n, or Location of Dea                        | th  | 4c. County of Death<br>Prince George                |  |
| Funeral  |             |  | rs. last birthday) If Under 1   |  | rs 8 Date of Birt                         | th (MM/DD/YYYY) 9. Bir                              |  |
| Director   |             |  | Months  | Days Hours M.                                | in  | Foreig  | n 吾手。  |
|  |             | 225 - 95 - 3858 1 X M 2 F 34  Usual Residence of Decedent  | Yrs.  |  | 0/10                                      | /1978 co  | Salvado:   |
| , any  |             | 10a. State 10b. County 10c. C  | City, Town or Location  |  |   |   | 10d, Inside City Limits                            |
| and show   | <b>a</b>    | MD PG. 72  | 2 Shelby DR.  | Oxon Hil                                     | 1 MD 21                                   | 0.45  | 1 X Yes 2 No                                       |
| Maryland<br>28a-f show any<br>d at once.   | Director    | 10e. Street and Number   | 10f. Zip Coo  | de   | 10  | g. Citizen of What Cour                             | ntry?  |
| the ?  | ₫           | 722 Shelby DR,   | 220   | 45   |   | EL Salvado  | \r   |
| 17215-0036 Id be filed within 72 hours after death with the Maryland fental Hygiene. arked other than "natural", or items 23a or 28a-f shoverent, the Medical Examiner must be notified at once.   | Funeral     | 11. Marital Status 12. Was Decedent Ever in Armed Forces?  | n U.S. 13. Was Decedent o   |  | Specify Yes or No-                        | 14. Race - Ameri                                    |  |
| or its   | Fun         | 1 Yes 2 X No   | •   | iban, Mexican, Puen                          | o Rican, etc.)                            | White, etc.   |  |
| rs afte<br>iral",<br>miner   | þ           | 3 Widowed 4 Divorced If Yes, Giva Yaar or Dates:  15. Decedent's Education (Specify only highest grade completed     | T <del>X</del> -  | No specify:                                  |   |   | <u>ite</u>   |
| 2 hou<br>"nati   | Completed   | Elementary/Secondary (0-12) College (1-4 or 5+)  | ) 16a. Decedent's Usual Occ<br>during most of working                       | upation (Give kind of<br>life. DO NOT use re | work done<br>tired)                       | 16b. Kind of Business/li                            | ndustry  |
| 336<br>thin 7<br>se.<br>than<br>edica  | Jdu         | 6  | Laborer   |  |   | self-em   | nloved   |
| 215-0036 be filed within 72 ntal Hygiene. rked other than "  | S           | 17. Father's Name (First, Middle, Last)  |   | 18.Mother's Nam                              | e (First, Middle, M                       |   |  |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than   | Be          | Dimas Gomez  |   | Maria El<br>Elizabe                          | sy Segov                                  | aiden Surname)<br>ia de Gomez<br>Jesus Zela         | 202  |
| N 3 4 8 0  | ဥ           | 19a. Informant's Name/Relationship (Type, Print )  | 19b. Mailing Address (S   | treet and Number or                          | Rural Route Numb                          | ber, City or Town, State,                           | Zip Code)  |
| ≥ da da se da Se |             | Jose Raul Pastor  20a. Method of Disposition   120   | 3224 Blond  | ell RD.I                                     | alls C                                    | nurch VA  | 22042  |
| <b>₹</b> 8 9 <b>₽</b> 2  |             | 1 Surial 2 Cremation 3 Removal from State  | <ul> <li>Place of Disposition (Name of crematory or other place)</li> </ul> | cemetery,                                    | Date                                      | 20c. Location - City or                             | Fown, State  |
| t. Pag<br>tment<br>rtant:  |             | 4 Donation 5 Other Specify:  | Family Cemet  | ery 5/                                       | 8/2012                                    | El Salva  | dor  |
| Baltimo<br>permit. Page<br>Department<br>Important:<br>injury or otl   |             | 21. Signature of Funeral Service Licensee  | 22. Name and Add  | W .  | H. Baco                                   | on F.H.   |  |
| Physician  | _           | 23a. Part I. Enter the disease, or complications that caused the dea   | 3447 14   | TH ST N                                      | IW WA                                     | DC20010   | Approximate later of                               |
| /Medical   |             | failure. List only one cause on each line.   |   | rig, odd r do cardiac                        | or respiratory arres                      | st, shock, or near                                  | Approximate Interval<br>Between Onset and<br>Death |
| Examiner   |             | Immediate Cause (Final disease or condition resulting in death)  a. Carbon Monoxide To:  Due to (or as a consequence |   | -  | <del></del>                               |   | Deatri   |
|  |             | Sequentially list conditions, b.   | ,   |  |   |   |  |
|  | ine         | if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause                               | e of):  |  |   |   |  |
|  | Examiner    | (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence)                  | e of):  |  |   |   |  |
| 760, icate be executed physician and the burial - transit  | Ë           | d  |   |  |   |   |  |
| be exurial   | Medical     | UNPENDED AMENDED   |   |  |   |   |  |
| 760, ficate be g physic sthe burn  |             | IF FEMALE: 23c. If yes, outcome of pro<br>23b. Was decedent pregnant in the  |   |  |   | 23d. Date of delivery                               |  |
| ox 68 sath certification of use as   | ciar        | past 12 months?  |   | 3Ectopic pregna                              | ancy                                      | Month Da  | ay Year  |
| Box 68 e death certif the attending ed for use as  | Physician   | 1 Yes 2 No 9 Unknown 9 Unknown   | Uther (Specify)   |  |   |   |  |
| P.O. es that the igned by t  | 1941        | Part II. Other significant conditions contributing to death but no   | t resulting in the underlying caus  | e given in Part I.                           | 23e. Did tob                              | acco use contribute to th                           | ne cause of death?                                 |
| s, P.C<br>uires that<br>signed i   | ed by       |  |   |  | 1 Yes                                     | 2 No 3 Proba  | bly 4 Unknown                                      |
| ord: w requires been should  | Completed   |  |   |  | 24a. Was an autopsy                       |   | ppsy findings available mpletion of cause of       |
| Rec<br>The la  | E           |  |   |  | perform<br>1 Yes 2                        | ned? death?   | _  |
| Vital Reco<br>ysician: The law<br>his certificate has<br>director, page 2 si   | Be          | 25. Was case referred to medical examiner?   | 26.Pla  | ace of Death (Check                          |   |   |  |
| g ig ig ig   | P           | 1 ✓ Yes 2 No Inpatient 2   | ER/Outpatient 3 DOA   | Other Nursin                                 | ng Home 5 R                               | esidence 6 🗸 Other:                                 | Scene  |
| n of ding Ph   | Ë           | 27. Manner of Death  1 Natural 5 Panding (Month: Day, Year)  | EQUIND:   | njury at Work?                               | 28d. Describe ho                          | w injury occurred<br>nome furnace exha              | nust   |
| Sion<br>Attender<br>Treath<br>Treath<br>Treath<br>Treath<br>Treath<br>Treath<br>Treath   | Cat         | 2 Accident Investigation Apr 24, 2012  | 1003 hrs  | Yes 2 ✔ No                                   |   |   |  |
| Division ppital or Attendia ours after death. reral Director: A  | Certificati | - Suicide Codid Hot be   | home, farm, street, factory, offic  | e building, etc.                             | or Town, Sta                              | eet and Number or Rura<br>te)                       | I Route Number, City                               |
| Lospit<br>4 hour   |             | 4 Homicide (Option) Single Fa  |   | 4-1  |   | re, Oxon Hill, MD                                   |  |
| Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b   | Medical     | one) 2 Medical Examiner: On the basis of examination   | and/or investigation, in my opini   | on, death occurred a                         | due to the cause(<br>at the time, date an | s) and manner as stated<br>Id place, and due to the | l.<br>cause(s)                                     |
| F . 2 E .  | Æ           | 29b. Signature and title of certifier  |   | nse number                                   |   | 29d. Date signed (Monti                             |  |
| A  |             | Caral Donn   | 0.0   | C.M.E.                                       |   | April 25, 2012                                      |  |
| CH   | ŀ           | 30. Name and address of person who completed cause of death (Ite   | em 23a)   |  |   |   |  |
| 4  |             | Carol Allan, MD Assistant Medical Examiner   |   | et, Baltimore, M                             | D 21223                                   |   |  |
| St.<br>Regist  |             | 31. Date filed (Mogth, Day Year) 32. Registrar's Signal  | ature   |  |   |   |  |

DGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Month April ам 25 Margarita С. Hurtarte Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2405 Lyttonsville Road Silver Spring Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 577-64-9448 **Director** 1 🗆 M 2 🔀 F 89 June 17, 1922 Guatemala 28a-f show with the Maryland notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 X No MD Montgomery Silver Spring 10e. Street and Number r items 23a or ner must be n ö 10f. Zip Code 10g. Citizen of What Country? Funeral 2405 Lyttonsville Road 20910 Guatemala 72 hours after death ı "natural", or iten ledical Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 □XYes 2 □ No Specify: Guatemalan 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) within 7 Elementary/Secondary (0-12) College (1-4 or 5+) 6 Housekeeper Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked or traumatic ever ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Aureliano P. Cano Braulia R. Delcid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Luis F. Escobar/Son 14105 Dub Drive, Laurel, MD 20708 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1  $\stackrel{\mbox{\scriptsize X}}{\mbox{\scriptsize Burial}}$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State cemetery, crematory or other place, April 30 2012 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD Gate of Heaven Cemetery Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph i i i Lymphoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) If any Leaving to immedicause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and the burial-trail that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death detached g 🗌 Unknown 9 I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 2 🖾 No 1 ☐ Yes 2 ☐ No Yes director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital Other: 2 X No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) this the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5  $\square$  Pending injury work? 1 ☐ Yes 2 ☐ No s after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f, Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical TECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

チ

Jocelyne

31. Date filed (Month, Day Year)

Jocelyne Kouatchou, MD

4041 Powder Mill Road, Calverton, MD 20705

April 26, 2012

Kouartchou, m)

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Apri CHARLOTTE FRANCES HANNA unknowm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4120 Houcks Road Harford Monkton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Maryland 1 M 2 X F Months Days Hours Mir 76 **Director** 5-32-9920 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
 It after 12 is marked other than "natural", or items 23a or 28a-f sho trant: If item 27 is marked other than "natural", or items 23a or 28a-f sho lury or other traumatic event, the Medical Examiner must be notified at lury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f s notified 1 🗌 Yes 2 💢 No MDHarford Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Completed by Funeral 4120 Houcks Road 21111 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc 1 Never Married 2 Married 2 **X** No Yes Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry n and Mental Hygiene.

I is marked other than "r traumatic event, the Med (Give kind of work done during mest of working life. DO NOT use retired) Beauty Service Elementary/Seconday (0-12) College (1-4 or 5+) Beautician/ Bus Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Harold Fosnot Margaret Ida Ritter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211324905 Clermont Mill Rd. Pylesville, MD. Valerie J. McKay (Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 2012 tsville Cem. Jarrettsville, . Signature of Funeral Service/Lice 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Maryland Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director; After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Year cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes **Division of Vital** 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 X Yes Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Nesidence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred **Natural** 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier R. Olso 29c. License number )150n, 00015044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Olson

32. Registrar's Signatury

17321

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 2012 5:55 P Dorothy Burdell Himes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1324 Weverton Rd. Knoxville Washington 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 212-68-7617 **Director** 1 □ M 2 🖾 F 10/26/1922 MD 89 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Knoxville Washington 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? "natural", or items 23a or Funeral 1324 Weverton Rd. 21758 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify. Completed 3 X Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Store Owner Grocery and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Irene Baker Stanley Minnick Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai Gary Himes/son 1324 Weverton Rd., Knoxville, MD 21758 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Brownsville Cemetery 04/23/2012 Brownsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly one cause on each line. 23a. Part 1. Enter the disease shock, or heart failurg. Li Interval Between Immediate Cause (Final Onset and Death Physician) ar kunson's disease or condition 10avs Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death be detached the 9 Unknown 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ artery disease 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform certificate 2 🗌 No 1 🗌 Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 27. Manner of Death 1 Natural 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined the Hospital Medical 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number . Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

0

Ka

31. Date filed (Month, Day, Year)

Registrar's Signature

60

North ave

|                            |  |                       | AMEND #21  | Plea<br>1, PER         | se Type of<br>R FD G928<br>State                            | r Prir<br>6/2<br>of Ma | it in B<br>27/12<br>iryland |                        |                        |                        |                        | and M       | <b>III Copie</b><br>Mental Hy       | s Are            | e Leg<br>e       | jible.                             |                                      |                   |
|----------------------------|--|-----------------------|--|------------------------|---|------------------------|-----------------------------|------------------------|------------------------|------------------------|------------------------|-------------|-------------------------------------|------------------|------------------|------------------------------------|--------------------------------------|-------------------|
|                            |  |                       | State<br>Registrar   |                        |   |                        |                             | Cer                    | tificat                | e of E                 | Death                  |             |                                     | Reg. N           | 0. 2             | 0                                  | 2 14                                 | 94                |
|                            | Physicia   | an/                   | 1. Decedent's Name (F  |                        | · ·   |                        |                             |                        |                        |                        |                        |             | 2. Date of De<br>APRIL              | 19               | ay 2             | o Year                             | 3. Time of E                         |                   |
| A. P. L.                   | Medi<br>Examir   |                       | ALEX HO  4a. Facility Name (if not   |                        |   | mber)                  |                             |                        | 4b. City.              | Town, or               | Location               | of Death    | AFKIL                               |                  | c. County        |                                    |                                      | JAIM              |
|                            |  |                       | LAURELWCO  | D NUR                  | SING HOM  | E                      | (In yrs. las                | t hirthday)            |                        | LKTO                   | N                      | r 24 Hrs.   | 0 Date of Bi                        |                  | or oounty        | CEC                                | IL                                   | Familian.         |
|                            | Funeral<br>Director  |                       | 160-20-557<br>Usual Residence of Dec   | 0                      | 6. Sex<br>1 <b>X</b> M 2 □ F                                | 7. Age                 | 85                          | Yrs.                   | Months                 | Days                   | Hours                  | Min.        | 8. Date of Bi<br>Month, Da<br>NOV • | rtn<br>ay, Year) | 926              |                                    | nplace (State or NSYLVAN             |                   |
|                            | land<br>show<br>d at   | ţ                     |  | b. County              |   |                        | 10c. City,                  | Town or Lo             | cation                 |                        |                        |             |                                     |                  |                  |                                    | 10d. Inside City                     | Limits            |
|                            | Mary<br>28a-f<br>iotifie   | Director              | MARYLAND   | CECI                   | L   |                        | N                           | ORTH                   | EAST                   |                        |                        |             |                                     |                  |                  |                                    | 1 🗆 Yes :                            | 2 X No            |
|                            | ith the<br>3a or<br>t be r   | ralD                  | 10e. Street and Numbe 647 MECHAN   |                        | ATTEV DO  | A D                    |                             |                        | 10f. Zip               |                        | 901                    |             |                                     | -                | itizen of \ ITED |                                    | -                                    |                   |
| 21215-0036                 | s filed within 72 hours after death with the Maryland tal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at  | ed by Funeral         | 11. Marital Status  1  Never Married  3  Widowed 4 X   | 2 Marri                | 12. Was Dec<br>Armed F                                      | cedent Evorces?        | ver in U.S.<br>No           |                        | Vas Deced<br>Yes, spec | lent of Hi<br>ify Cuba | spanic Or<br>n, Mexica |             | cify Yes or No-<br>Rican, etc.)     |                  | 14. Rac          | e - Amer                           | ican Indian,                         |                   |
| 5-0                        | 2 hou<br>"natu<br>edical   | plet                  | 1.<br>(Specify   | 5. Deceden             | t's Education<br>et grade completed                         | d)                     |                             | 16a. Deced             | lent's Usua            |                        |                        | st of worki | na                                  | 16b. l           | Kind of B        | usi <b>ne</b> ss I                 | ndustry                              |                   |
| 121                        | ed within 7<br>Hygiene.<br>other than<br>ent, the M  | Completed             | Elementary/Second  | lay (0-12)             | College (   | 1-4 or 5+              | -)                          |                        | O NOT use<br>[ERAL     | ,                      | ERVIS                  | SOR         |                                     | EL               | ECTR             | TC C                               | OMPANY                               |                   |
| pd 2                       | filed wall Hygi  | Be                    | 17. Father's Name (First   | t, Middle, La          | ast)  |                        |                             | OZI                    | Didib                  |                        |                        |             | e (First, Middle                    |                  |                  |                                    | 0111 11111                           |                   |
| ylaı                       | Mental Mental Marked of atic even  | 욘                     | SAMUEL HO  | LOTAN                  | KO  |                        |                             |                        |                        |                        | MAF                    | RY (U       | NKNOWN)                             | )                |                  |                                    |                                      |                   |
| Maryland                   | 2 should be fil<br>Ith and Mental<br>27 is marked of<br>tranmatic ev   |                       | 19a. Informant's Name  |                        |   |                        |                             |                        |                        |                        |                        |             | l Route Numbe                       |                  |                  |                                    | <i>'</i>                             |                   |
|                            | and<br>Hea<br><b>tem</b>   |                       | ALEX HOLOT<br>20a. Method of Disposi   |                        | JR. / SO  | <u>N</u>               | 20b. Pla                    | ce of Dispo            | sition (Nan            | ne of                  | - 1                    |             | OAD NO                              |                  |                  |                                    | ARYLAND 2<br>Town, State             | 21901             |
| mo                         |  |                       | 1 ☐ Burial 2 <b>XX</b> 0<br>4 ☐ Donation 5 Î   | Cremation Other (St    | 3 ☐ Removal from  | n State                |                             | netery, cren<br>CRDALE |                        |                        |                        |             | L 21,                               |                  |                  | -                                  | LAWARE                               |                   |
| Baltimore,                 | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.   |                       | 21. Signature of Funera  |                        |   |                        |                             |                        |                        |                        |                        |             | CCH FUI                             |                  |                  |                                    |                                      | 1001              |
| _                          | <u> </u>   | V 9                   | ROBERT  23a. Part 1. Enter the o   |                        | ROUCH (PI   |                        |                             |                        |                        |                        |                        |             |                                     |                  | EAST             | , MA                               | RYLAND2                              | 1901              |
| , Jan                      | Medical<br>Examiner  | Examiner              | shock, or heart fa<br>Immediate Cause (Fina<br>disease or condition<br>resulting in death)  Sequentially list condit<br>in any, leading to imme<br>cause. Enter Underlyin<br>Cause (Disease or linju | al<br>tions,<br>eciate | a. Due to   | elo<br>(or as a<br>VI  | consequer                   | M                      | 'C                     | Pn                     | ost                    | ale         | - Ca                                | n Ce             |                  | -                                  | Interval Betwe<br>Onset and De       | een<br>eath       |
|                            | Hospital or Attending Physician: The law requires that the death certificate be executed far hours after death.  Funeral Director: After this certificate has been signed by the attending physician and ated filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Medical Exa | that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pre   |                        | d   | ) (                    | f <u>pr</u> egnanc          | enl                    |                        | ı                      |                        |             |                                     |                  | 23d. Da          | te of deli                         | very                                 |                   |
| . Box                      | requires that the death certific<br>been signed by the attending I<br>should be detached for use as  | hysicia               | in the past 12 mon<br>1 ☐ Yes 2 ☐ N<br>9 ☐ Unknown   |                        |   | gnant at               | time of dea                 | death 3 Lath 5 C       | Other (sp              |                        | У                      |             |                                     |                  | Мо               | nth                                | Day Yea                              | ar                |
| P.O.                       | s that t<br>gned b<br>e deta   | by P                  | Part II. Other significar  | nt conditio            | ns contributing to  | death bu               | t not result                | ing in the u           | nderlying o            | ause giv               | en in Part             | :I.         | 23e. Did t                          | obacco           | use contr        | ibute to                           | the cause of dea                     | ath?              |
| rds,                       | aquires<br>aen siç<br>ould b   | ted                   |  |                        |   |                        |                             |                        |                        |                        |                        | <del></del> | 1 🗆                                 | Yes 2            | □No              | 3 Pro                              | obabiy 4₺ Ur                         | nknown            |
| CO                         | law re<br>has by   | Completed             |  |                        |   |                        |                             |                        |                        |                        |                        |             | 24a. Was<br>auto                    | psv              | 1 1              | Vere auto<br>prior to co<br>death? | opsy findings av<br>ompletion of cau | ailable<br>use of |
| Ä                          | sician: The law I<br>certificate has b<br>lirector, page 2 s   |                       | 25. Was case referred to   | o medical              | -1  |                        |                             |                        |                        | 26 DI                  | and of Dog             | ath (Check  | 1 Ves                               | 2 🗹 N            | lo               |                                    | 2/1 No                               |                   |
| Vita                       | ysicia<br>s certi<br>directo   | To Be                 | examiner?<br>1  Yes 2 N  |                        | Hospital:   | Inpatier               | nt 2 🗆 EF                   | R/Outpatien            | t 3 🗆 DO               | Othe                   | ari d                  | _           | me 5 Resi                           | dence (          | 6 □ Othe         | er (Snecil                         | iv)                                  |                   |
| of                         | ng Ph<br>fter thi  |                       | 27. Manner of Death  | Pending                | 28a. Date   |                        | 28                          | Bb. Time of injury     |                        | 8c. Injury<br>work     | at                     |             | 28d. Describe                       |                  |                  |                                    | 7/                                   |                   |
| ion                        | ttendii<br>death.<br>tor: Ai<br>the fu   | Certificate:          | 2 Accident   | Investig               | ation   | - 41-1                 |                             |                        | М                      | 1 🗆 '                  | Yes 2                  | _           |                                     |                  |                  |                                    |                                      |                   |
| Division of Vital Records, | al or Al<br>s after (<br>al Directed in by   |                       | 4 🗌 Homicide   | determin               | 28e. Place  |                        | y - At home<br>(Specify)    | e, farm, stre          | et, factory            | , office               |                        | Į,          | 28f, Location (8<br>City or Tov     |                  |                  | er or Run                          | al Route Number                      | ,                 |
|                            | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,   | Medical               | (Check 2   | Medical Ex             | Physician: To the<br>aminer: On the ba<br>Nurse Practioner: | asis of exa            | amination a                 | nd/or invest           | igation, in r          | ny opinio              | n, death o             | occurred at | the time, date a                    | and place        | e, and due       | to the ca                          | ause(s) and mann                     | ner stated.       |
|                            | To the i   |                       | 29b. Signature and title   |                        | 2 acu   | ۸).                    |                             |                        |                        | License                |                        |             |                                     |                  | ate signed       |                                    | Day, Year)                           |                   |
|                            |  |                       | 30. Name and address   |                        |   |                        | ath (Item 2                 | 3a) (Type, P           |                        |                        |                        |             |                                     |                  |                  | . , -                              |                                      |                   |
| $\forall i$                | A  |                       | Dr. Sheelme  | ohan S                 | Sachdev.  | 126 1                  | East                        | High                   | Stree                  | et, S                  | Suite                  | #1,         | E1kton                              | ı, Ma            | ary1a            | and                                | 21921                                |                   |
|                            | Sta<br>Registra  |                       | 31. Date filed (Month, D   | APR 2                  | 3 90 32.  | Registrar              | 's Signatur                 | e                      | ho as A                | 1                      |                        |             |                                     |                  |                  |                                    |                                      |                   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Aaron Hardy Jr Physician/ 7803P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex Birthplace (State or Foreign Country)
 DC 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 578-70-0728 **Director** 1 🗶 M 2 🗆 F April 1953 Usual Residence of Decedent show ms 23a or 28a-f sho must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DC 1 X Yes 2 □ No Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ral", or items 23a Examiner must be Funeral 1006 15th Street SE 20003 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes If Yes, Give 2X No Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private Truck Driver 11th Be Itimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Aaron Hardy Sr Mattie Lee Gaffney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 15th St SE Washington DC 20003 LaTricia White Hardy -Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Apri<sup>Date</sup> 24 2012 1 Burial 2 Cremation 3 N Removal from State Ft Lincoln Cem. Brentwood Md 4 Donation 5 DO Other (Special CC0257 Funeral ervice L 22. Name and Address of Facility Bal McLaughlin Funeral Home 2518 Pennsylvania Ave SE Wash DC 20020 23a. Part y Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. shock, or heart failure. List only one cause on each Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** ALLMONARY DISPASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Tes 2 No Other: 은 1 Inpatient 2 ER/Outpatient 3 I DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work?
1 Yes 2 No Accident 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide determined City or Town, State) Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) D679 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Castro m.o. Elena Road 8118 6000 Luch

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

|  |                     |  | Plea                 | se Type or                                 |             |                      |  |                                   |                  |                                | •                               |                  | •                     | gible.                         |   |              |
|--|---------------------|--|----------------------|--|-------------|----------------------|--|-----------------------------------|------------------|--------------------------------|---------------------------------|------------------|-----------------------|--------------------------------|---|--------------|
|  |                     | For<br>State<br>Registrar  |                      | State                                      | or iviar    | yland                |  | irtment of<br>tificate of         |                  |                                | лентат пу                       | rgiene<br>Reg. N | -                     | 0 1 1                          | 2 1                                       | l. 0 l.      |
| H  |                     | 1. Decedent's Name   |                      | . ,  |             | <del></del>          |  | imouto o                          |                  |                                | 2. Date of De                   | eath             |                       | - <del></del>                  | 3. Time o                                 | f Death      |
| Physicia<br>Medic  |                     | Harold D   |                      |  |             |                      |  |                                   |                  |                                | Month<br>Apri                   | 1 6              | 33_                   | 2012                           | 11:5                                      | 5 AM         |
| Examin   | er                  |  |                      | , give street and nur<br>al Center         | nber)       |                      |  | 4b. City, Town                    |                  |                                |                                 |                  |                       | y of Death                     |   |              |
| Funeral  |                     | 5. Social Security N   | umber                | 6. Sex                                     | 7. Age (II  | n yrs. la            | st birthday)   | Hager<br>If Under 1 Ye            | ar If Ur         | nder 24 Hrs.                   | 8. Date of Bir                  | rth              | wası                  | ingto                          | lace (State o                             | or Foreign   |
| Director   |                     | 171-30-7   |                      | 1 🛮 M 2 🗆 F                                | 7           | 74                   | Yrs.   | Months Day                        | s Hou            | irs Min.                       | 09-09                           |                  | 37                    | Penns                          | sylvan                                    | ia           |
| and<br>show<br>dat   | tor                 | 10a. State   | 10b. County          |  | 1           |                      | , Town or Loc  | ation                             |                  |                                |                                 |                  |                       | 1                              | 0d. Inside C                              | ity Limits   |
| Maryl 28a-f  | irec                | PA   | Frank                | lin  |             | Mar                  | ion  |                                   |                  |                                |                                 |                  |                       |                                | 1 🗆 Yes                                   | 2XX No       |
| vith the<br>23a or<br>st be r  | Funeral Director    | 10e. Street and Nun  |                      | Street                                     |             |                      |  | 10f. Zip Code                     |                  |                                |                                 | 10g. C           |                       | What Coun                      | try?                                      |              |
| eath w   | -une                | 11. Marital Status   | orago .              | 12. Was Dece                               |             | r in U.S.            | . 13. V  | /as Decedent o<br>Yes, specify Cu |                  | Origin? (Spe                   | ecify Yes or No-                |                  |                       | ce - Americ                    | an Indian,                                |              |
| should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at   | ρ                   | 1 X Never Marri<br>3 ☐ Widowed   |                      | If Yes, Giv                                | 2 🔯 No<br>e | )                    |  | Yes, specify Co                   |                  |                                | Rican, etc.)                    |                  |                       | ck, White, e<br>/: <b>whit</b> |   |              |
| hours<br>natura<br>dical E   | Completed           |  | 15. Deceder          | nt's Education                             | ates.       |                      | 16a. Deced   | ent's Usual Occ                   | upation          |                                |                                 | 16b.             | Kind of E             | Business/Ind                   | dustry                                    |              |
| hin 72<br>ne.<br><b>than</b> "   | omb                 | Elementary/Seco  |                      | est grade completed,<br>College (1         | -4 or 5+)   | $\dashv$             | life. DC   | ind of work dor<br>NOT use retire | e auring i<br>d) | most of work                   | ing                             |                  |                       |                                |   |              |
| ed wit<br>Hygie<br>other<br>ent, th  | Be C                | 11<br>17. Father's Name (I   | First, Middle, L     | .ast)                                      |             |                      | Super  | visor                             | 18. N            | lother's Nam                   | e (First, Middle,               | _                |                       | ment                           |   |              |
| d be fill<br>Vental<br>Arked<br>rtic ev  | ၀                   | George W   | . Hauln              | nan Sr.                                    |             |                      |  |                                   | 10.19            |                                | len Mul                         |                  | Garrian               | ٥,                             |   |              |
| ge 1 and 2 should be<br>it of Health and Men<br>if item 27 is marke<br>or other traumatic  |                     | 19a. Informant's Na  |                      | nip (Type, Print)                          |             |                      |  | g Address (Stre                   |                  |                                |                                 | -                |                       |                                |   |              |
| and 2<br>Health<br>tem 2;  |                     | Todd Glas<br>20a. Method of Disp   |                      | son  |             | 20h Pla              |  | olorado                           | St.              |                                | 137, Ma                         |                  |                       | A. 17                          |   |              |
| Page 1<br>ent of<br>nt: If it  |                     |  | Cremation            | 3 Removal from                             | State       | ce                   | emetery, crem  | atory or other p                  |                  | i                              |                                 |                  |                       | •                              |   |              |
| permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau  |                     | 21. Signature of Fur   |                      |  |             | 1110                 |  | Name and Add                      |                  |                                | 2012                            | Ond              | moer                  | Bbare                          | ,, 1111                                   |              |
| 9 Q T # 9  | _                   |  | NE                   | STA  |             | 346                  |  | omas L.                           |                  |                                |                                 |                  | , Ch                  | amber                          | sburg                                     | , PA         |
| Dhunining/   |                     | shock, or hear<br>Immediate Cause (  | rt failure. List c   | complications that only one cause on ea    | ch line.    | e death              | . Do not ente  | the mode of a                     | ring, such       | as cardiac o                   | or respiratory ar               | rest,            | 7/                    | 7                              | Approximat<br>Interval Bet<br>Onset and I | ween         |
| Physician/<br>Medical  |                     | disease or condition resulting in death)   |                      | a. Due to                                  | oras a co   | onseque              | ence of):  | ras                               |                  | ngo                            | VCCP                            | 10               | -                     |                                | 1   |              |
| Examiner   | -E                  | Sequentially list con  | nditions,            | b  | h           | 90                   | 18   | Full                              |                  | He                             | art                             | 10               | ull                   | te                             | Yeer                                      | S            |
| ted<br>Insit   | Examiner            | Sequentially list con<br>if any, leading to im-<br>cause, Enter Under<br>Cause (Disease or | injury               | Due to                                     | or as a co  | ngeque<br>Vi         | ence of):  | 1087                              | 11               | MC                             | 70                              | 1,56             | 205                   | Se!                            | 400                                       | 411          |
| ii al 6  | - 1                 | that initiated events<br>resulting in death) l   |                      | c. Due to                                  | or as a     | ons <del>eq</del> ue | ence of  |                                   | 2. 1             | 0 /1                           | 200                             | 11               | 11                    | 2                              | <u> </u>                                  |              |
| ate be<br>ohysici<br>the bu  | dica                |  |                      | L d. 67/11                                 | 8/2         | 201                  | MLC  | 8UM                               | UX.              | ) [ je                         | ILLE                            |                  |                       | 1 6                            | yay.                                      | 3~           |
| certific<br>nding a  | ı√W                 | IF FEMALE:<br>23b. Was decedent  | pregnant             | 23c. If yes, out                           |             |                      |  |                                   |                  |                                |                                 |                  | 23 d. Da              | ate of delive                  | irv                                       |              |
| death<br>e atte  | sicia               | in the past 12 r   | nonths?              | 1 Live<br>4 Preg<br>9 Unkr                 | nant at tir |                      |  | Other (specify)                   | ncy              |                                |                                 |                  |                       | _                              |   | Year         |
| requires that the death certificate be execut<br>been signed by the attending physician and<br>should be detached for use as the burial-tra  | by Physician/Medica | 9 Unknown Part II. Other signif  | icant condition      | ns contributing to d                       | eath but i  | not resu             | iting in the ur  | derlying cause                    | given in F       | Part I.                        | 23e. Did to                     | obacco           | use cont              | ribute to th                   | e cause of d                              | eath?        |
| juires t<br>en sign<br>ruld be   | ed b                | (  | 1.78                 | ball                                       |             | TI                   | mi   | 140                               | 0                | 2                              | 1 🗆                             | Yes 2            | □ No                  | 3 Prob                         | ably 4 🗌                                  | Unknown      |
| aw rec<br>as bee   | Completed           |  | Val                  | ve   | W A         |                      | op   | Cacou                             | We               | M                              | 24a. Was                        | psy              | _                     | prior to cor                   | sy findings a                             |              |
| : The licate h   |                     | 05.14  | HO                   | -09  | Q K         | w                    | S  | 497                               | nj               | 2400                           | Yes Yes                         | ormed?           |                       | death?<br>1  Yes               | 2 🗌 No                                    |              |
| /sician<br>s certif<br>directo   | To Be               | 25. Was case referre examiner?  1  Yes 2   | No medical           | Hospital:                                  | Innatient   | 2 N                  | R/Outpatient   | 1/10                              | ther:            | Death (Check                   | only one) me 5 🗆 Resid          | donos            | 6 🗆 Oth               | or (Coocifu)                   |   |              |
| ng Phy<br>fter this<br>ineral  |                     | 27. Manner of Death  | 5 Pendin             | 28a. Date                                  |             | 2                    | 28b. Time of injury  | 28c. ln                           |                  |                                | 28d. Describe h                 |                  |                       |                                |   |              |
| ttendii<br>death.<br>tor: Ai<br>the fu   | Certificate:        | 2 Accident 3 Suicide   | Investig             | gation                                     |             |                      |  | M 1                               | Yes 2            | 2 □ No                         |                                 |                  |                       |                                |   |              |
| al or A  |                     | 4 Homicide   | determ               |  | ng, etc. (S |                      | ne, farm, stre   | et, factory, offic                | 3                |                                | 28f. Location (S<br>City or Tox |                  |                       | er or Rural                    | Route Numb                                | er,          |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director. | Medical             | 29a. Certifier 1<br>(Check 2   | Certifying Medical E | Physician: To the b<br>xaminer: On the bas | est of my   | knowle               | dge, death o   | ccurred at the ti                 | me, date         | and place, and the occurred at | nd due to the ca                | ause(s) a        | and manr<br>e, and du | ner as state                   | d.<br>se(s) and ma                        | nner stated. |
| fo the vithin 2 fo the comple  | ž                   | only or e) 3<br>29b. Signature and t   | Certifying           | Nurse Practitioner                         | To the be   | est of my            | y knowledge,   | death occurred a                  | t the time       | , date and pla                 | ace, and due to t               | the cause        | e(s) and r            | manner as s<br>d (Month, E     | tated.                                    |              |
| 25.00  |                     | 1 Aid  | a                    | gryli                                      | )           |                      |  | 12                                | 002              | 150                            | 37                              | APA              | 2/2                   | 23                             | 2013                                      | ۷,           |
| 3081   |                     | 30. Name and addre   | ess of person v      | who completed caus                         | e of death  | h (Item 2            | 23a) (Type, Pr   | int)<br>24 B                      | Oi.              | ullo                           | faru                            | A                | 11                    | 16 N                           | 1021                                      | 740          |
| State  | _                   | 31. Date filed (Month  |                      | 32. R                                      | egist ar's  | Signatu              | ire de la constitución de la con |                                   | CN .             |                                | 1- 64.1                         | 1/               |                       |                                |   |              |
| Registra   | r                   | MAY 1  | 2012                 | (laura)                                    | P.          |                      |  |                                   |                  |                                |                                 |                  |                       |                                |   |              |

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Ana Rubio MD.

0 4 2012

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

32. Registra s Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 73 × M Physician/ 8ºU EANOR 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b, City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours Min (Month, Day, Year) 014-24-3412 **Director** 1 □ M 2**X**□ F Yrs. Nov. 11, 1927 | Massachusetts 84 Usual Residence of Decede 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State notified at 1 X Yes 2 No Maryland | Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be r Funeral 20716 USA |2215 Hyde Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Comptroller Private Sector 2+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Dorothy Sunderman Gordon Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2215 Hyde Lane Bowie, MD 20716 Roy E. Jensen/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Lakemont
orial Gardens 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/25/2012 Davidsonville, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signatore of Funeral Service Licenses By 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lin // Onset and Death Immediate Cause (Final Physician/ RUTONITIS disease or condition Medical resulting in death) GALLSTUNE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical nding p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Month Year Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? ģ CARDIAC 1 Yes 2 No 3 Probably 4 Unknown Records, Completed AORTIC VALVE DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No Yes 25. Was case referred to medical **Division of Vital** Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2- No 1 Yes 1-Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? thin 24 hours after death.

the Funeral Director: After mipletely filled in by the fur 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2. only one) 29b. Signature and title of certi-30 Name and address of person wholcombleted cause of death (Item 23a) (Type, Print)

OFFENSE Hwy Year) 32. Red State APR 25 2012

Registrar DHMH 17 Rev 06-2011

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRTL 1 2 2 2012 PARKE H. JOHN 04:25PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10 SECOND STREET, RED POINT CECIL NORTH EAST 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days PENNSYLVANIA JUNE 23, **Director** 202-07-8935 92 Usual Residence of Decedent 28a-f shov 10a. State 10b. County must be notified at 10c. City, Town or Location Director 1 ☐ Yes 2X No MARYLAND CECIL NORTH EAST 10e. Street and Number ö 10g. Citizen of What Country? 23a Funeral 10 SECOND STREET, RED POINT 21901 UNITED STATES death v 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ö 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after Specify: WHITE 1 Yes 2 X No Specify. Completed 3 XXWidowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) FOOD Elementary/Seconday (0-12) College (1-4 or 5+) 12 VICE PRESIDENT MANUFACTURING other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F i. Page 1 and 2 should be file tment of Health and Mental rant: If item 27 is marked o ပ RAYMOND JOHN HELEN SCHUYLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PARKE H. JOHN, JR. / SON 57 VIRGINIA AVENUE, NORTH EAST, MARYLAND 21901 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or other 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State NORTH te EAST to UNITED (CO) 16, APRIL 4 Donation 5 Other (Specify) NORTH EAST, MARYLAND 2012 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. STREET, NORTH EAST, MARYLAND 21901 23a. Part 1. Enter the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List ofly one cause on each line. Approximate Interval Return Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as 1 attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Pregnant at time of death Year 2 No the a Unknown g Unknown Ś been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 page performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: Aft bleted filled in by the fur Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature

5+IVA

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

llon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ April 23, Day 012 Year 9:30 Ernest Joseph Jones Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Davs Min Hours 215-34-0322 **Director** 1 🕱 M 2 🗆 F Usual Residence of Decedent 75 May 7, Maryland ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29 Laughton Street 20774 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black. White, etc. "natural", or <u>Ş</u> 1 Never Married 2 X Married 2 X No Maryland 21215-0036 72 hours after Specify: African American 1 ☐ Yes 2 🖾 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired)  $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12\,\text{th} \end{array}$ College (1-4 or 5+) and Mental Hygiene. Is marked other tha Upholsery Specialist Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Albert Jones Rebecca Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Diana Lucille Nick Jones / Wife 29 Laughton Street Upper Marlboro, Maryland other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State Page 1 ApriPat30. cemetery crematory or other place)
Lakemont
Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Davidsonville, Md. 21. Signature of Funeral Service Licens 24 22. Name and Address of Facility Stewart Funeral Home, Inc. Stewar lun M00560 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sici\_n Gall Bladder Cancer with Metastasis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Acute Renal Failure Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) -transit executed resulting in death) Last Due to (or as a consequence of) burialphysician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Dav Year 2 🗌 No signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page performed? Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🕱 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 XNatural 5 Pending s after death. 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 04-23-2012 D65729 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-201

31. Date filed (Month, Day, Ye APR 2 8 2012

Farzad Melakanian 1500 Forest Glen Road Silver Spring, Maryland 20910

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Apr 28, 2012 6:00PM <sup>M</sup> Garland James 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 509 Pine Avenue Allegany Cumberland Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Days 1 XM 2 🗆 F Min . 19<u>48</u> Jun 10, 235-82-4958 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Cumberland Allegany 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 509 Pine Avenue 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married 1 🗆 Yes 2 🖹 No If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sacred Heart Hospital Housekeepina 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carrie L Houdershall Ray O. James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 509 Pine Avenue Cumberland MD 21502 Virginia James wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 ☐ X remation 3 ☐ Removal from State 5/2/2012 Scarpelli Funeral Home, P.A. MD Donation 5 Other (Specify) Cresaptown ignature of Funeral Service Lic 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) coronan Due to (or as a consequent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

certificate be Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this

Physician/

Medical

Director

Funeral

ģ

Completed

Be

ပ္

Examiner

**Funeral** 

Director

notified

28a-f

ms 23a or must be r

ral", or items? Examiner mus

"natural",

Il Hygiene.

Ith and Mental H 27 is marked of traumatic ever

t of Health

ò

Department of Important: If any injury or once.

Physician/

Medical

the burial-transit and

as

nse

for

pe

þ

has

certificate

funeral director,

filled in by the I

physician

Examine

Physician/Medical

by

Completed

Be

မ

Certificate:

Medical

Natural Accident Suicide

Homicide

29b. Signature and title of certifier

29a. Certifier

5 Pending

Investigation

6 Could not be

Examiner

Medical

the

filed within 72 hours after

Page 1 and 2 should be

Saltimore, Maryland 21215-0036

сопретед

State Registrar

rikramaditya Koonau MD 9 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

~

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Virginia O. Kelly 2012 11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Aberdeen Morgan Lane 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Min (Month, Day, Year) Hours 220-22-1963 Usual Residence of Decede **Director** 1 □ M 2 🏋 F 84 Yrs 08-25-1927 Virginia 28a-f show 10c. City, Town or Location 10d Inside City Limits aţ 10a. State 10b. County Director Examiner must be notified 1 Yes 2 X No Aberdeen Maryland Harford 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21001 U.S.A. 3 Morgan Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 0. by 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates White 1 ☐ Yes 2 ☐ No Specify: "natural", 3 Widowed 4 Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Victoria Hall Herman Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

You Huntington. W. V. 35705 : Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) Millicent A. Sarvas (Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04-28-2012 Darlington, <u>Darlington Ce</u>me 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S Washington St., Havre de Grace, MD 21. Signature of Funeral Sen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. nterval Between set and Death Immediate Cause (Final ehydration Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law has autopsy page 2 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 1 Yes 2 No Investigation Accident Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year D32609 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harre De Gran MD 21078 rep 1166 Revalution St rydin MILLIAM 32 Registrar's Signat State

Registrar

|                                 |  |                   | 7&8 per Please 4/30/12 cs   |                                |  |                        |                             |                                     | re All Copie                                  |                               | _                             |   |
|---------------------------------|--|-------------------|---|--------------------------------|--|------------------------|-----------------------------|-------------------------------------|---|-------------------------------|-------------------------------|---|
|                                 |  | ٠.                | For State Registrar   | State of h                     | viaryiari                              |                        |                             | of Death                            | na wentai ny                                  |                               | 001                           | 0 1105                                    |
|                                 |  |                   | Decedent's Name (First, Middle, La.   | st)                            |  | 007                    | incate                      | or Douter                           | 2. Date of De                                 | Reg. N                        | io. 2 U                       | 3. Time of Death                          |
|                                 | Physicia<br>Medi   |                   |   | Margaret                       | Louise                                 | King                   |                             |                                     | Month 04                                      | 2                             | 9ay Year 2012                 | 4:48 P M                                  |
|                                 | Examir   |                   | 4a. Facility Name (if not institution, give                                     |                                |  | <b>_</b>               | 4b. City, Tox               | vn, or Location of                  | Death   |                               | c. County of Dea              |   |
| -                               | <i>t</i>   |                   | 4108 Maryland Highway   |                                |  |                        |                             | Oaklar                              |   |                               |                               | rrett                                     |
|                                 | Funeral<br>Director  |                   | 5. Social Security Number 6. S  228-30-7808 1  Usual Residence of Decedent      |                                | Nge (In yrs. Ia<br>187 — <del>86</del> | st birthday)<br>Yrs.   | If Under 1 Months D         | ear If Under 20<br>ays Hours        | 4 Hrs. 8. Date of Bi (Month, Di -05/19 02/01  | ay, Year)<br>71 <del>92</del> | S- Co                         | thplace (State or Foreign<br>untry)<br>VA |
|                                 | shov<br>dat  | to                | 10a. State 10b. County  |                                | 10c. City                              | , Town or Lo           | cation                      |                                     |   |                               |                               | 10d. Inside City Limits                   |
|                                 | Men<br>28a-  | Director          |   | rrett                          |  |                        |                             | Oaklan                              | d   |                               |                               | 1 ☐ Yes 2 🗷 No                            |
|                                 | death with the Meryland<br>Items 23e or 28a-f sho<br>ner must be notified at   |                   | 10e. Street and Number  |                                |  |                        | 10f. Zip Co                 |                                     |   | 10g. 0                        | Citizen of What Co            |   |
|                                 | ath wi   | Funeral           | 4108 Maryland Highway  11. Marital Status                                       | 12. Was Deceden                | t Ever in U.S.                         | 12.1                   | Mac Docadoni                | 21550                               | n? (Specify Yes or No                         |                               | US.                           |   |
|                                 | or Ite   | by F              | 1 Never Married 2 Married   | Armed Forces                   | ?<br><b>10</b> No                      | . 13.                  | f Yes, specify              | Cuban, Mexican,                     | Puerto Rican, etc.)                           | -                             | 14. Race - Ame<br>Black, Whit |   |
| 93                              | rs aft   |                   | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dates. |  |                        | 1 ☐ Yes 2 🖟                 | No Specify:                         |   |                               | Specify:                      | Vhite                                     |
| 5-0                             | 2 hou<br>"net.   | plet              | 15. Decedent's E<br>(Specify only highest gr                                    |                                |  | 16a. Dece              | dent's Usual C              | ccupation<br>one during most o      | of working                                    | 16b.                          | Kind of Business              |   |
| Baltimore, Maryland 21215-0036  | permit. Page 1 and 2 should be filed within 72 hours after death with the Meryland Depertment of Health and Mentel Hyglene. Importent: If item 27 is marked other then "neture!", or Items 23e or 28a-f show with jujury or other treumatic event, the Medical Examiner must be notified at once.  | Completed         | Elementary/Secondary (0-12)   | College (1-4 o                 | r 5+)                                  |                        | O NOT use re                |                                     | <b>.</b>                                      |                               | Coal In                       | dustry                                    |
| Pu                              | filed el Hyg   | Be                | 17. Father's Name (First, Middle, Last)   |                                |  |                        |                             | 18. Mother                          | 's Name (First, Middle                        | , Maidei                      | n Sumame)                     |   |
| Уa                              | Ment<br>Ment<br>narke  | ျ                 |   | harles T. Bro                  | wn                                     |                        |                             |                                     | Gra   | ce M.                         | Handy                         |   |
| Mar                             | shou<br>hand<br>is n   |                   | 19a. Informant's Name/Relationship (1   | ,, ,                           |  | 1                      | ,                           |                                     | or Rural Route Numb                           |                               | or Town, State, Zi            | o Code)                                   |
| ,<br>-                          | end 2<br>Healt<br>em 2   |                   | Richard E. King / Husban  20a. Method of Disposition                            | <u>d</u>                       | 20h BI                                 | •                      | aryland F<br>sition (Name o |                                     | kland, MD 21.                                 |                               | Location - City or            | Town State                                |
| nor                             | ege 1<br>ant of<br>it: If if   |                   | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci                      | Removal from Sta               |  | emetery, crer          | natory or othe              | place)                              | Date  | 200.                          |                               |   |
| 葺                               | nit. Pertme  |                   | 21. Signature of Funeral Service Licen  |                                |  |                        | ark Cemeter  Name and A     | ddress of Facility                  | 4/28/2012                                     |                               | Deer Par                      | rk, MD                                    |
| ä                               | Depermine Depermine Important Irraportal Irr |                   | 16 CH   | M                              |  | Į.                     |                             |                                     | Jame PA 21 No.                                | rth Sec                       | and Street Oc                 | ıkland, MD 21550                          |
|                                 |  |                   | 23a. Part 1. Enter the disease, or com<br>shock, or heart failure. List only of | plications that caus           | ed the death                           |                        |                             |                                     |   |                               | on on co                      | Approximate<br>Interval Between           |
|                                 | Physician/   | a s               | Immediate Cause (Final disease or condition                                     | /_                             | 1 = 00.                                | raillu                 | 5 Fum                       | inatus v                            | Neumoni                                       | 2                             |                               | Onset and Death                           |
|                                 | Medical Examiner   |                   | resulting in death)   | a. Due to (or a                | s a seque                              | ence of):              |                             | 1 1                                 | J. Curright                                   |                               |                               |   |
|                                 | Examiner   | <u>.</u>          | Sequentially list conditions,   | b                              | (0                                     | ro                     |                             |                                     |   |                               |                               | yeurs                                     |
|                                 | ed<br>nsit   | Examiner          | if any heading to immediate cause. Enter Underlying Cause (Disease or injury    | UNH TO (UF B                   | to ba                                  |                        | ue                          |                                     |   |                               |                               | Years                                     |
|                                 | n and<br>lal-tre   | Exa               | that initiated events resulting in death) Last                                  | C. Due to (or a                | s a consequ                            |                        | معتد                        |                                     |   |                               |                               | /   |
| 8                               | requires that the death certificete be executed been signed by the ettending physician and should be detached for use as the burlal-trensit  | lical             |   | d                              |  |                        |                             |                                     |   |                               |                               |   |
| Box 68760                       | tificet<br>ng ph   | Physiclan/Medical | IF FEMALE:  |                                |  |                        |                             |                                     |   |                               |                               |   |
| ×                               | th cer<br>ttendi   | lan/              | 23b. Was decedent pregnant in the past 12 months?                               | 23c. If yes, outcom            | 2 Fetal                                | death 3                |                             |                                     |   | - 1                           | 23d. Date of de<br>Month      | livery<br>Dav Year                        |
| B                               | e dea<br>the e   | ysic              | 1 ☐ Yes 2 DXNo<br>9 ☐ Uriknown  | 4 ☐ Pregnant<br>9 ☐ Unknow     |  | eath 5 L               | Other (speci                | fy)                                 |   |                               | MONUN                         | Day fear                                  |
| Ö.                              | hat the ed by detac  | 판                 | Part II. Other significant conditions of  | ontributing to death           | but not resu                           | ulting in the u        | inderlying cau              | se given in Part I.                 | 23e. Did                                      | tobacco                       | use contribute to             | the cause of death?                       |
| 'n                              | n sign   | Completed by      | Chronic Respi   | ratory for                     | Jure                                   | his                    | tory of                     | non Since                           | <u>/</u> 1 🕏                                  | Yes :                         | 2 □ No 3 □ F                  | robabły 4 🗌 Unknown                       |
| Ö                               | w requ   | Pleto             | cell lung lances  | 1. H700                        | UTI                                    | GE                     | RDI                         | 1/0 DY7                             | 24a. Was                                      |                               |                               | topsy findings available                  |
| ခိုင                            | The lar  | Ę                 |   |                                |  |                        |                             | · · · · · ·                         | auto<br>perf<br>1 ☐ Yes                       | ormed?                        | death?                        | completion of cause of                    |
| <u> </u>                        | sten:  | Be (              | 25. Was case referred to medical examiner?                                      |                                |  |                        | 2                           | 6. Place of Death                   |   | - <b>A</b> 3.                 |                               |   |
| Ξ                               | hysic<br>this ce<br>al dire  | <u> </u> 2        | 1 ☐ Yes 2 DX No   |                                |  |                        | nt 3 □ DOA                  |                                     | sing Home 5 Res                               | idence                        | 6 Other (Spec                 | sify)                                     |
| n 0                             | ding F<br>h.<br>After<br>funer   | Certificate:      | 27. Manner of Death 1   Natural 5 □ Pending                                     | 28a. Date of in<br>(Month, D   |  | 28b. Time of<br>injury | 1200.                       | Injury at<br>work?<br>1 ☐ Yes 2 ☐ N | 28d. Describe                                 | how inju                      | iry occurred                  |   |
| sio                             | Attend<br>r deatl<br>ctor:<br>by the   | Į≝                | 2 Accident Investigatio 3 Suicide 6 Could not t                                 |                                | niury - At hor                         | me. farm. str          | M<br>eet. factory, of       |                                     |   | Street a                      | nd Number or Ru               | ral Route Number,                         |
| Division of Vital Records, P.O. | al or /<br>s effer<br>I Dire   |                   | 4 ☐ Homicide determined   |                                | etc. (Specify)                         |                        | oot, idoloty, o             |                                     | City or To                                    |                               |                               | rai riodie Namber,                        |
|                                 | To the Hospital or Attending Physicien: The law requires that the death certificete be executed within 24 hours effer death.  To the Funerel Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-trensities.   | Medical           |   |                                |  |                        |                             |                                     | lace, and due to the durred at the time, date |                               |                               | ated.<br>cause(s) and manner stated.      |
|                                 | thin 2<br>the l  | Me                |   |                                |  |                        | death occurre               |                                     | and place, and due to                         | the caus                      | se(s) and manner a            | s stated.                                 |
|                                 | ¥ ≥ ₽ 8  |                   | A Common of Common  | Lotra                          |  |                        | 290. LI                     |                                     |   | 290. D                        | atersigned (Monta             | h, Day, Year)                             |
|                                 | •  |                   | 30. Name and address of person who  | completed cause of             | death (Item                            | 23a) (Type 5           | Print)                      | H00647                              | /05   | - (                           | 100/00                        | ,   |
|                                 |  |                   | Richard Porter, D.O. 311  |                                |  |                        |                             | 21550                               |   |                               |                               |   |
|                                 | Sta  |                   | 31. Date filed (Month, Day, Year)   | 32. Regis                      | trar's Signati                         |                        | 4                           |                                     |   |                               |                               |   |
|                                 | Registr  | ar                | APR 2 7 201   | L Chan                         | N B.                                   | gar                    |                             |                                     | -   |                               |                               |   |

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

|  |                  |   | Plea                                 |                |  |  |                |                                      |                        |                       |   |                      | II Copie                           |                  |                               | ble.                     |                  |                              |
|--|------------------|---|--------------------------------------|----------------|--|--|----------------|--------------------------------------|------------------------|-----------------------|---|----------------------|------------------------------------|------------------|-------------------------------|--------------------------|------------------|------------------------------|
|  | _                | For<br>State  |                                      |                | State c  | of Mary  | land           | •                                    |                        |                       |   | and M                | 1ental Hy                          | /giene           | 9                             | 2 1                      | 0                |                              |
| -  |                  | Registrar  1. Decedent's Name   | e (First, Middle                     | , Last)        |  |  |                | Cer                                  | tificat                | e of L                | <i>Jeath</i>                            |                      | 2. Date of D                       | Reg. N           | 0.                            | Ш                        | 7<br>1 a Tin     | ne of Death                  |
| Physiciar<br>Medica  |                  | Agnes   | Mary                                 | Lar            | ngley  | •  |                |                                      |                        |                       |   |                      | 0 <sup>Menth</sup> 2               |                  | <b>512</b>                    | Year                     |                  | :20ам                        |
| Examine  |                  | 4a. Facility Name (if   |                                      | _              |  |  |                |                                      |                        |                       | Location of                             | f Death              |                                    |                  | c. County o                   |                          |                  |                              |
|  |                  | Villa R  5. Social Security N   |                                      | ursi<br>6. Sex | ing H  | Ome 7. Age (In   | um loot        | hirthday                             | Lar<br>If Unde         | nham                  | If Under 2                              | 0/ ∐re               | 0 Data - ( D)                      |                  | ince                          |                          |                  |                              |
| Funeral<br>Director  |                  | 219-16-<br>Usual Residence of   | 2393                                 |                | М 2 <b>Ж</b> ] F   |  | yrs. 1451<br>5 | Yrs.                                 | Months                 | Days                  | Hours                                   | Min.                 | 8. Date of Bi<br>(Month, D<br>08/1 |                  | 16                            | 9. Birth<br>Co <i>ut</i> | place (State) MD | ate or Foreign               |
| and<br>show<br>dat   | ō                | 10a. State  | 10b. County                          | -              |  | 100  | c. City, 7     | Town or Loc                          | cation                 |                       |   |                      |                                    |                  |                               |                          | 10d. Insid       | de City Limits               |
| Mary<br>28a-f<br>otifie  | irec             |   | Princ                                | e Ge           | eorge  | 's   |                | Lanh                                 |                        |                       |   |                      |                                    |                  |                               |                          | 1 <b>X</b>       | Yes 2 No                     |
| s 23a or   | Funeral Director | 10e. Street and Nur<br>7213 Ke  |                                      | Roa            | ad   |  |                |                                      | 10f. Zip<br>2 (        | 0706                  | 5                                       |                      |                                    | 10g. C           | itizen of W                   | hat Cou                  | ntry?            |                              |
| imir, o  | ام<br>ا          | 11. Marital Status<br>1 ☐ Never Marr<br>3 ☐ <b>X</b> Widowed                              |                                      | ried           | Nas Dece<br>Armed Fo<br>1 ☐ Yes<br>If Yes, Giv<br>Year or Da | rces?<br>2 🔀 No<br>re  | in U.S.        | "                                    | f Yes, spec            | cify Cuba             | ispanic Orig<br>n, Mexican,<br>Specify: | in? (Spe<br>Puerto I | cify Yes or No<br>Rican, etc.)     | -                | 14. Race<br>Black<br>Specify: | , White,                 |                  |                              |
| n 72 hou<br>e.<br>ian "natu<br>Medical   | Completed        | (Spe  | 15. Deceder<br>cify only highe       |                |  |  |                | life. DO                             | kind of wo             | rk done d<br>retired) | ation<br>during most                    | of worki             | ng                                 |                  | Kind of Bus                   |                          | dustry           |                              |
| d withi  | Be C             | 6   |                                      |                | 0011090 (1   | 10101)   | H              | Iouse                                | keer                   | er                    |   |                      |                                    |                  | riva                          | te                       |                  |                              |
| ld be file<br>Mental H<br>arked ot<br>atic ever  | 2<br>2           | 17. Father's Name (i  |                                      | ,              |  |  |                |                                      |                        |                       |   |                      | Forre                              |                  | Surname)                      |                          |                  |                              |
| id 2 shou<br>saith and<br>n 27 is m<br>er traum  |                  | 19a. Informant's Na<br>Mary El  |                                      |                |  | on/d   | ltr            | 19b. Mailin                          | g Address<br>Ker       | Street a              | and Number<br>on Rd                     | or Rura<br>• L       | Route Numb                         | er, City o<br>MD | r Town, Sta                   | ate, Zip<br>706          | Code)            |                              |
| Page 1 an<br>nent of He<br>int: If iten<br>iry or oth  |                  | 20a. Method of Disp<br>1 🔀 Burial 2<br>4 🗌 Donation                                       | ☐ Cremation                          |                | moval from   | State  | cem            | ce of Dispo<br>netery, cren<br>Peter | natory`or o            | ther place            | e) M                                    |                      | ) ate , 2012                       |                  | ocation - 0                   |                          |                  | :e                           |
| permit. Departr Importa any injt   | İ                | 21. Signature of Fu   | neral Service                        | icensee        | /  |  |                |                                      |                        |                       | ss of Facility                          | Bri                  | scoe-To                            | onic             | Fune                          | ral                      | Home             | }                            |
|  |                  | 23a. Part 1, Enter t  | he disease, or<br>rt failure. List o | complica       | ations that o  | caused the   | death. [       |                                      |                        |                       |   |                      |                                    |                  |                               |                          | Approx           | imate<br>I Between           |
| Physician/<br>Medical  |                  | Immediate Cause (<br>disease or condition<br>resulting in death)                          |                                      | a.             |  | izhe,<br>(or as a cor  |                |                                      | Den                    | neut                  | ta                                      |                      |                                    |                  |                               | $\perp$                  |                  | and Death                    |
| Examiner   | _                | Sequentially list co  | nditions,                            | b.             |  |  | ,              |                                      |                        |                       |   |                      |                                    |                  |                               |                          |                  |                              |
| uted<br>Id<br>ansit  | Examiner         | if any, leading to im<br>cause. Enter Under<br>Cause (Disease or<br>that initiated events | rlying<br>iinjury                    | C.             | Due to (   | or as a cor  | nsequen        | ice of):                             |                        |                       |   |                      |                                    |                  |                               |                          |                  |                              |
| 90 FE 12   | <u>a</u>         | resulting in death) I   |                                      | L d.           | Due to (   | (or as a cor   | nsequen        | ice of):                             |                        |                       |   |                      |                                    |                  |                               |                          |                  |                              |
| tificate ng ph)  | Med              | IF FEMALE:  |                                      | T -            |  |  |                |                                      |                        |                       |   |                      |                                    | T                |                               |                          |                  |                              |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but | Physician/Medic  | 23b. Was decedent<br>in the past 12<br>1  Yes 2<br>9  Unknown                             | months?                              | 230            |  | Birth 2  nant at time  | Fetal d        | leath 3 🗌                            | Ectopic  <br>Other (sp |                       | У                                       |                      |                                    |                  | 23d. Date<br>Mont             |                          | ery<br>Day       | Year                         |
| lires that the dea<br>signed by the a<br>Id be detached f  | by Ph            | Part II. Other signif   | icant condition                      | ns contr       | ibuting to d   | eath but no  | ot resulti     | ing in the u                         | nderlying (            | cause giv             | en in Part I.                           |                      | 23e. Did                           | tobacco          | use contrib                   | ute to t                 | ne cause         | of death?                    |
| requires to been signal per should be  | g p              | Diaber  | tes                                  |                |  |  |                |                                      |                        |                       |   |                      | 1 🗆                                | Yes 2            | □ No 3                        | ∃ Pro                    | bably 4          | Unknown                      |
| sician: The law rec  | Completed        | Hyper   | fensi                                | M              |  |  |                |                                      |                        |                       |   |                      |                                    | opsy<br>ormed?   | pri<br>de                     | ior to co<br>eath?       | mpletion         | ngs available<br>of cause of |
| ian: Ti<br>rtificat<br>ctor, pa  |                  | 25. Was case referre  | ed to medical                        |                |  |  |                |                                      |                        | 26. Pla               | ace of Death                            | n (Check             | 1 \(\sime\) Yes<br>only one)       | 2 L N            | lo 1 1                        | ⊔ Yes                    | 2 🗌 No           |                              |
| Physician:<br>this certific<br>al director,  | ၉                | 1 Yes 2   |                                      | Hos            |  |  |                | R/Outpatien                          |                        |                       | 4 Lat Nur                               | rsing Ho             | me 5 Res                           | idence (         | 6 🗌 Other                     | (Specify                 | )                |                              |
| ending P<br>eath,<br>or: After t<br>he funera  | Certificate:     | 27. Manner of Death  1 Natural 2 Accident   | 5 Pendin<br>Investig                 | gation         | 28a. Date<br>(Moni   | of injury<br>th, Day, Yea  |                | Bb. Time of injury                   | M 2                    | 8c. Injury<br>work    |   |                      | 28d. Describe                      | how inju         | ry occurred                   | 1                        |                  |                              |
| To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completed filled in by the funeral   |                  | 3 ☐ Suicide<br>4 ☐ Homicide   | 6 Could determ                       |                |  | of Injury - and of Injury - an |                | e, farm, stre                        | eet, factory           | , office              |   |                      | 28f. Location (<br>City or To      |                  |                               | or Rura                  | Route N          | 'umber,                      |
| ne Hospit<br>n 24 hou<br>ne Funera<br>pleted fill.   | Medical          | (Check \ 2  | Certifying Medical E Certifying      | xaminer        | : On the bas   | sis of examin  | nation ar      | nd/or invest                         | igation, in            | my opinio             | on, death occ                           | curred at            | the time, date                     | and place        | e, and due t                  | o the ca                 | use(s) and       | d manner stated.             |
| Vithi<br>To th   |                  | 29b. Signature and  | title of certifier                   |                |  |  |                |                                      | 290                    | License               | number                                  |                      |                                    | 29d. Da          | ate signed (                  | Month,                   | Day, Year        | )                            |
| 6  |                  | P Ye  | MY                                   | 0              | 20   | 1  |                |                                      |                        | DO                    | 05333                                   | 37                   |                                    | Hpr              | 1/2                           | 4 2                      | 510              |                              |
| 60,0   |                  | 30. Name and addre  | ess of person                        | who com        | ND "   | 283  | 55             | Soul                                 | rint)<br>(M. A.        | re ?                  | Ste 20                                  | FE                   | Seltin                             | we               | Md-                           | 2(2                      | υq               |                              |
| State<br>Registra  |                  | 31. Date filed (Mont  | 26 201                               | 2              | 32. R  | egistrar's S   | ignature       | back                                 | 1                      |                       |   |                      |                                    |                  |                               |                          |                  |                              |

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 10 1 Zucen 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death ()6K COUNT No mos Under 1 Year Birthplace (State or Foreign Country) MD If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days (Mopth/83/1940 Months Min Hours 220-34-2174 71 Director Yrs Usual Residence of Decedent show 10a. State 10b. County should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director Oakland MD Garrett 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1461 Smouse Road 21550 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces

1 Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 A Married Completed by 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced 4 Divorced 1962 - 1964 Specify. White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 18b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic/Electrician Coal Industry 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Errice O. Liller Mary B. Moon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Donna Liller / Wife 1461 Smouse Road, Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important; If ite Date ò cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State injury o 4/27/2012 4 Donation 5 Other (Specify) Oakland, MD Garrett County Memorial Gardens Signature of Funeral Service Licens 22. Name and Address of Facility Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ eus (arch Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine il any, leading to immediate cause. Enter Underlying Due to (or as a consequence or). To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Month Pregnant at time of death Dav Year cate has been signed by the page 2 should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) 2 No Other: မ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this Inpatient 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗀 No Natural injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 30. Nan 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MATO C 1922 Harold LEFFERTS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 1 🛛 M 2 🗆 F 164-16-3182 91 July 21 1920 Pennsylvania or 28a-f show 10a, State 10b. County 10c. City, Town or Location must be notified at Director 1 Yes 2X No Maryland | Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? Funeral 17823 Greentree Lane USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married X Yes 2 □ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Completed 3 Widowed 4 Divorced Year or Dates 1942-44 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Police Officer City Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Lefferts Florence (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Janet Lefferts - Wife 17823 Greentree Lane, Hagerstown, Maryland 21740 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 5/1/2012 Hagerstown, Maryland 21. Signatur Fineral Service License 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ NEUMONI disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Dav Year 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the inderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 212009 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛕 Unknown HR20NIC 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performed Yes 2 1 🗌 Yes 2 🗌 No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 Hospital Inpatient 2 ER/Outpatient 3 DOA Other: ပ္ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Manner of De Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RROTTE 31. Date filed (Month, Day, State Registrar

12-03190 Nora N. Leiva

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| lora I           | N. Leiva  |  | 1-For StateMEND#17per FH   | yland / Depai<br>5 / 1 / 1 2C研            | fiment of                           | Health ar<br>Death           | nd Mental  | F                                      | Reg. No. 201                       | 2 1496                                       |  |  |  |  |
|------------------|---|--|--|---|-------------------------------------|------------------------------|--|--|------------------------------------|--|--|--|--|--|
| Medi             | Physici<br>cal Exami  | an/<br>iner  | 1. Decedent's Name (First, Middle,Last)  Nora Nohemi Leiva   |   |                                     |                              |  | 2. Date of Dea<br>Month<br>April 24, 2 | Day Year                           | 3. Time of Death<br>1110 hrs                 |  |  |  |  |
|                  |   |  | 4a. Facility Name (if not institution, give street an  | d number)                                 | 4                                   | b. City, Town, o             | r Location of De   |  | 4c. County of Deat                 |  |  |  |  |  |
|                  | Funeral   |  | 722 Shelby Drive  5. Social Security Number 6. Sex   | 7. Age (In yrs. las                       | st birthday)                        | If Under 1 Ye                | ar If Under 24   | Hrs. 8. Date of B                      | Prince Georg                       |  |  |  |  |  |
|                  | Director  |  | 337-98-9846 1□M 2x   | F 57                                      | Yrs.                                | Months Da                    | ys Hours M   | 10/0                                   | 07/1954 Forei                      | <sup>gn</sup><br>D <sup>untry)</sup> Lapaz   |  |  |  |  |
|                  | w any   |  | Usual Residence of Decedent  10a. State  10b. County   | 10c. City, 7                              | Fown or Location                    | on                           |  |  |                                    | 10d. Inside City Limits                      |  |  |  |  |
|                  | faryland<br>28a-f show<br>  at once,  | tor  | IL COOK  10e. Street and Number  | Chic                                      | cago                                | 10f. Zip Code                |  | 1.                                     | 10g. Citizen of What Cou           | 1 Yes 2 No                                   |  |  |  |  |
|                  | the Mar<br>or 28,   | Director   | 6640 S. Kedvale Av   | e.  |                                     | 60629                        | )  |  | EL Salvad                          | -  |  |  |  |  |
|                  | hours after death with the Maryland<br>"natural", or items 23a or 28a-f sh<br>Examiner must be notified at once | Funeral  | 1 Never Married 2 X Married Arme   | Decedent Ever in U.S<br>ed Forces?        |                                     |                              | ispanic Origin? (<br>nn, Mexican, Pue  | Specify Yes or Norto Rican, etc.)      | 0- 14. Race - Amer<br>White, etc.  | rican Indian, Black,                         |  |  |  |  |
|                  | after de:<br>nl", or i  | by Fu  | 3 Widowed 4 Divorced If Yes, Giv. or Dates:  |   | 1                                   | Yes 2 N                      | o specify:   |  | Specify: Whi                       | .te  |  |  |  |  |
|                  | hours 'natur  |  | 15. Decedent's Education (Specify only highest   | grade completed) ge (1-4 or 5+)           |                                     |                              | ation (Give kind on the contract of the contra |  | 16b. Kind of Business              | Industry                                     |  |  |  |  |
| 350              | ed within 72 hours a tygiene.  other than "natura the Medical Examin  | Completed  | 6 TH   | ge (1~4 01 5+)                            | opera                               | ator                         |  |  | self-em                            | ployed                                       |  |  |  |  |
| 24245_0036       | be filed within ntal Hygiene. rked other tha  | 4  | 17. Father's Name (First, Middle, Last) _Teodosio_   |   |                                     |                              | 18.Mother's Na   | me (First, Middle,                     | Maiden Surname)                    | <u> </u>                                     |  |  |  |  |
| 24.9             | uld be fil<br>Mental F<br>marked<br>c event,  | To Be  | "Peodora Inocencio  19a. Informant's Name/Relationship (Type, Print  | Leiva                                     | 19b. Mailing                        | Address (Stre                | Gloria<br>et and Number  | Elisa<br>or Rural Route Nu             | Teiva<br>mber, City or Town, State | e, Zip Code)                                 |  |  |  |  |
| 5                | d 2 sho<br>lth and<br>n 27 is   |  |  | iece                                      |                                     |                              |  |  | clington V                         |  |  |  |  |  |
| 9                | Pages I and 2 shoument of Health and Paut: If item 27 is not or other traumatic                                 |  | 20a. Method of Disposition  1 Burial 2 Cremation 3 Remove  |   | ace of Disposit<br>ematory or other | ion (Name of ce<br>er place) |  | Date                                   | 20c. Location - City or            | ,  |  |  |  |  |
| Raltimore        | permit. Pages l Department of l Important: If injury or other   | 4 Donation 5 Other Specify: Family Cemetery 5/8/12 El Slav 21. Signature of Fur Fral Service Licensee 22. Name and Address of Facility W.H. Bacon FH.  |  |   |                                     |                              |  |  |                                    |  |  |  |  |  |
| å                | Dem<br>Inju   | W. H. Bacon FH.  W. H. Bacon FH.  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart |  |   |                                     |                              |  |  |                                    |  |  |  |  |  |
|                  | hysician<br>Wedical   |  | failure. List only one cause on each line.   |   |                                     | e mode of dying              | , such as cardia   | c or respiratory an                    | rest, shock, or heart              | Approximate Interval Between Onset and Death |  |  |  |  |
|                  | xaminer   |  |  | Monoxide Toxicit<br>as a consequence of): | <u> </u>                            |                              |  |  |                                    | Death  |  |  |  |  |
|                  |   | _  | Sequentially list conditions, if any leading to immediate Due to (or   | as a consequence of                       |                                     |                              |  |  |                                    |  |  |  |  |  |
|                  |   | Examiner   | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  d. |   |                                     |                              |  |  |                                    |  |  |  |  |  |
|                  | e be executed<br>ysician and<br>burial - transit  | EX   |  |   |                                     |                              |  |  |                                    |  |  |  |  |  |
| <u></u>          | e be exe<br>ysician a<br>burial -   | ledical  | UNPENDED AMEND   |   |                                     |                              |  |  |                                    |  |  |  |  |  |
| 876              | eath certificate be<br>attending physici<br>for use as the buri   | an/M   | past 12 months?  | res, outcome of pregna<br>ve birth        | 2 Feta                              | al death 3                   | Ectopic preg   | nancy                                  | 23d. Date of deliver<br>Month      | y<br>Day Year                                |  |  |  |  |
| Boy 6876         | death ce<br>le attend<br>I for use  | Physician/N  | 4 P  | regnant at time of deal<br>nknown         | th 5 Oth                            | er (Specify)                 |  |  |                                    |  |  |  |  |  |
| 0                | . ĕ '.ĕ   | by Ph  | Part II. Other significant conditions contributi   | ng to death but not res                   | sulting in the un                   | iderlying cause              | given in Part I.   |  | obacco use contribute to           |  |  |  |  |  |
|                  | een sign  | ted I  | ,  |   |                                     |                              |  | - 24a. Was                             |                                    | utopsy findings available                    |  |  |  |  |
| of Vital Records | e law r<br>e has b<br>ge 2 sh   | 24a. Was an autopsy prior to comply death?  1 Yes 2 No 1 Yes   |  |   |                                     |                              |  |  |                                    |  |  |  |  |  |
| <u> </u>         | ian: The<br>certificate   | Be Co  | 25. Was case referred to medical examiner?   |   |                                     | 26.Plac                      | e of Death (Che  |  | 2 10 1                             | es 2 No                                      |  |  |  |  |
| Š                | Physician:<br>or this certif  | ၉  | 1 ✓ Yes 2 No   |   | R/Outpatient<br>28b, Time of Inj    |                              | Other Nur  |  | Residence 6  Othe                  | r: Scene                                     |  |  |  |  |
|                  |   | tion:  | 1 Natural 5 Pending  | ND: Day,Year)                             | FOUND:<br>1003 hrs                  |                              | Yes 2 ✓ No   |  | home furnace exi                   | naust  |  |  |  |  |
| Division         | or Attend<br>after death<br>Director:<br>d in by the  | Certification:   | 3 Suicide 6 Could not be 28e.  | Place of Injury - At hon                  | ne, farm, street                    | , factory, office            | building, etc.   | or Town, S                             | Street and Number or Ru            | ıral Route Number, City                      |  |  |  |  |
| _                | To the Hospital or<br>within 24 hours afte<br>To the Funeral Dir<br>completely filled in                        | - 1  | 29a. Certifier   | best of my knowledge                      |                                     | ed at the time of            | late and place a   | 1                                      | erive, Oxon Hill, MD               | ed   |  |  |  |  |
|                  | To the Hospi<br>within 24 hou<br>To the Funer<br>completely fil   | Medical  | one) 2 Medical Examiner: On the ba   | sis of examination and                    |                                     |                              |  |  |                                    |  |  |  |  |  |
|                  | A   | Ž  | 29b. Signature and title of certifier  |   |                                     | 29c. Licens                  | se number<br>.M.E.   |  | 29d. Date signed (Mo               | nth, Day, Year)                              |  |  |  |  |
|                  | 44  |  | 30. Name and address of person who completed cause of death (Item 23a)   |   |                                     |                              |  |  |                                    |  |  |  |  |  |
|                  |   |  | Carol Allan, MD Assistant Medic  | cal Examiner 9                            | 00 W. Baltii                        | more Street                  | , Baltimore,   | MD 21223                               |                                    |  |  |  |  |  |
|                  | S<br>Regis  | tate<br>trar   | APR 2 2012 Server  | . Registrar's Signature                   | معلا                                |                              |  |  |                                    |  |  |  |  |  |
|                  |   | _  |  | -   |                                     |                              |  |  |                                    |  |  |  |  |  |

OGME

| 12-01793<br>Kristen Britany Loc  |  | ease Type o<br>State                     | r Print in Bl<br>of Maryland              |                 |                                 |                                   |                                |              |                                     | gible     |  | 0 1100                                    |
|--|--|--|---|-----------------|---------------------------------|-----------------------------------|--------------------------------|--------------|-------------------------------------|-----------|--|---|
|  | 1- For State<br>Registrar                    | - (First Still In the or                 |   | Certi           | ficate of                       | Death                             |                                |              |                                     | Reg. No.  | 201  |   |
| Physician/<br>Medical Examine  |  | Britney                                  |   |                 |                                 |                                   |                                | '            | 2. Date of Dea<br>Month<br>March 2, | Day       | Year   | 3. Time of Death<br>2353 hrs              |
|  |  | if not institution, give                 |   |                 | 4                               |                                   | n, or Location                 | n of Death   |                                     | 40        | County of Death                                    |   |
| Funeral  | 5. Social Security N                         | aryland Hospita                          |   | e (in yrs. lasi | t birthday)                     | Clinton  If Under 1               | Year If Un                     | nder 24Hrs.  | 8. Date of Bi                       |           | Prince George /DD/YYYY) 9. Bir                     |   |
| Director   | 575-55-3                                     |  |   | 2               | -                               |                                   | Days Hou                       |              | 12/23/                              | ,         | Foreig   |   |
| b  | Usual Residence of                           | f Decedent<br>10b. County                |   | 140- Oit. T     | own or Locati                   |                                   | L                              |              | 12/27                               | 1177      |  |   |
| d de any   | MD   | Charles                                  |   | Wald            |                                 | OII                               |                                |              |                                     |           |  | 10d. Inside City Limits  1 Yes 2 No       |
| the Maryland a or 28a-f show tified at once. Director  | 10e. Street and Nu                           | mber                                     |   |                 |                                 | 10f. Zip Co                       |                                |              | 1                                   | _         | izen of What Coul                                  | ntry?                                     |
| # ## <b> </b>  |  | ewood Cou                                |   |                 |                                 | 2060                              |                                |              |                                     | US        |  |   |
| sr death with<br>, or items 23<br>r.must be no<br>Funeral  | 11. Marital Status 1 X Never Marrie          | ed 2 Married                             | 12. Was Decedent<br>Armed Forces?         |                 |                                 |                                   | of Hispanic O<br>Cuban, Mexica |              | cify Yes or No<br>lican, etc.)      | 0-        | <ol><li>14. Race - Ameri<br/>White, etc.</li></ol> | can Indian, Black,                        |
| s after de ral", or niner m  | 3 Myldowed                                   |  | If Yes, Give Year<br>or Dates:            | X No            | 1                               | Yes 2 X                           | No specif                      | fy:          |                                     |           | Specify: Whi                                       | te  |
| bours :<br>Exami   | 15. Decedent's Ed                            | ducation (Specify on                     | ly highest grade com<br>College (1-4 or s |                 | 6a. Deceden<br>during mo        |                                   | cupation (Giv<br>g life. DO NO |              |                                     | 16b. I    | Kind of Business/I                                 | ndustry                                   |
| 5-0036 ed within 72 bour bygiene. other than "natu the Medical Exau  | . Lietheritary/3ecc                          | oridary (0-12)                           | 2   | 54)             | Stude                           | nt                                |                                |              |                                     | Co1       | lege of  | Southern M                                |
| Hygier Hy |  | ` '                                      |   |                 |                                 |                                   |                                |              | First, Middle,                      | Maiden    | Surname)   |   |
| MD 21215-0036 ad 2 should be filed within 7 tith and Mental Hygiene. m 27 is marked other than aumatic event, the Medical To Be Comple   |  | 01mutz<br>ime/Relationship (Ty           | Lock<br>rpe, Print )                      |                 | 19b. Mailing                    | Address (                         |                                |              | a Mar:                              |           | Cortez<br>ity or Town, State                       | Lock<br>Zip Code)                         |
| MD 12 shorth and 27 is numation  | William                                      | Olmutz Lo                                |   | ner             |                                 |                                   |                                |              |                                     | svil      | le, MD 2   | 20659                                     |
| ore, es l and of Heal  | 20a. Method of Disp<br>1 X Burial 2          | Cremation 3                              | Removal from Sta                          | ate cre         | ice of Disposi<br>matory or oth | er place)                         |                                |              | Date                                |           | Location - City or                                 |   |
| Baltimore,<br>permit. Pages I ar<br>Department of Hee<br>Importunt: If ite   | 4 Donation 5 21. Signature of Fu             | Other Specify:                           | 25000                                     | Arl:            | ington                          | Natio                             | nal Co                         | e 03/19      | 9/2012                              | Ar        | lington.   | VA<br>eral Home                           |
| Department injury  | Haway (                                      | l Schall                                 | ee M008:                                  | 1 /             |                                 |                                   |                                |              |                                     |           |  | eral Home<br>L, MD 20622                  |
| Physician  | 23a, Part I Enter th                         | e disease, or compli                     | cations that caused                       | the death. D    | o not enter th                  | e mode of d                       | ying, such as                  | cardiac or r | espiratory an                       | rest, sho | ock, or heart                                      | Approximate Interval<br>Between Onset and |
| /Medical<br>Examiner   | Immediate Cause (<br>or condition resulting  |  | Complicat Oue to (or as a conse           |                 | of Mort                         | id Ob                             | esity                          | <del></del>  |                                     |           |  | Death                                     |
|  | Sequentially list cor                        | nditions, b                              |   |                 |                                 |                                   |                                |              |                                     |           |  |   |
| niner  | if any, leading to im<br>cause. Enter Unde   | rlying Cause                             | Oue to (or as a conse                     | equence of):    |                                 |                                   |                                |              |                                     |           |  |   |
| ted<br>Insit<br>Examiner   | (Disease or injury the events resulting in a | nat initiated _                          | ue to (or as a conse                      | equence of):    |                                 |                                   |                                |              |                                     |           |  |   |
| executed an and at - transi  | X INPENDED                                   | d  | AMENDED 23a,                              | ,27,pe          | r me,g                          | 927 5-                            | -29-12                         | sm           |                                     |           |  |   |
| Division of Vital Records, P.C. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit ledical Certification: To Be Completed by Physician/Medical Ex   | IF FEMALE:                                   | proposed in the                          | 23c. If yes, outcon                       |                 |                                 |                                   |                                |              |                                     | 230       | d. Date of delivery                                |   |
| Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be as after death.  *I Director: After this certificate has been signed by the attending physic led in by the funeral director, page 2 should be deached for use as the bur errification: To Be Completed by Physician/Mec  | 23b. Was decedent past 12 months             | ?  | 1 Live birth 4 Pregnant at                | time of death   | , ~ 🖂                           | al death<br>er (S <i>pecify</i> ) |                                | oic pregnand | Cy                                  |           | Month D  | ay Year                                   |
| BO) ne death the att hed for   | 1 Yes 2 N                                    |  | 9 Unknown                                 |                 |                                 |                                   |                                | _            | T                                   |           |  |   |
| P.O.   | 100  | ficant conditions                        | contributing to death                     | n but not resu  | alting in the u                 | iderlying ca                      | use given in f                 | Part I.      |                                     |           | _  | the cause of death?  ably 4  Unknown      |
| Records,  The law require ficate has been significate basen significate Completed  |  |  |   |                 |                                 |                                   |                                |              | 24a. Was                            |           |  | topsy findings available                  |
| ecol<br>he law<br>ite has<br>age 2 st  |  |  |   |                 |                                 |                                   |                                |              | autop<br>perfo<br>1 <b>✓</b> Yes    | med?      | death?   | ompletion of cause of                     |
| cian: T certifical Rescription   | 25. Was case referrexaminer?                 |  |   |                 |                                 |                                   | Place of Deat                  | h (Check on  |                                     |           |  |   |
| f Vid  | 1 Yes  | 2 No                                     | ospital: 1 Inpatie                        |                 | R/Outpatient<br>8b. Time of In  |                                   | Other <sub>4</sub>             |              | Home 5 8d. Describe                 |           | nce 6 Other  | :   |
| Division o spital or Attending tours after death.  neral Director: After filled in by the func Gertification:  | 1 X Natural                                  | 5 Pending                                | (Month, Day,Ye                            | ear)            | ob. Titllo of it                |                                   | Yes 2                          | _            | od. Booking i                       | now myc   | ny occanica  |   |
| or Atto<br>or Atto<br>or Atto<br>or Atto<br>Directo<br>in by t   | 2 Accident 3 Suicide                         | Investigatio  6 Could not b              | e 28e. Place of Inj                       | jury - At home  | e, farm, stree                  | , factory, off                    | ice building,                  | etc. 2       | 8f. Location (S                     |           | nd Number or Ru                                    | ral Route Number, City                    |
| Ospital ospital interal is y filled  |  | determined                               | (0,000))                                  |                 |                                 |                                   |                                |              |                                     |           |  |   |
| Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b   | (Check only                                  | Certifying Physicia<br>Medical Examiner: | On the basis of exar                      |                 |                                 |                                   |                                |              |                                     |           |  |   |
| A S S S S  | 29b. Signature and                           |  | and manner stated.                        |                 |                                 | 29c. Li                           | cense numbe                    | er           |                                     | 29d. (    | Date signed (Mor                                   | oth, Day, Year)                           |
|  | Chres  |  |   |                 |                                 | °                                 | .C.M.E.                        |              |                                     | Mar       | ch 3, 2012   |   |
|  | Ana Rubio N                                  |  | ompleted cause of det<br>t Medical Exam   |                 |                                 | nore Stre                         | et, Baltim                     | ore, MD      | 21223                               |           |  |   |
| State  | 2011 23 37 11                                |  | 32. Registrar                             |                 |                                 |                                   |                                |              |                                     |           |  |   |
| Registrar  | 4 1 11 11                                    | V 4014                                   | men p                                     | . 190           | Vien                            |                                   |                                |              |                                     |           |  |   |

UGIAE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Lillian Theresa Masterson 04/27/2012 11:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 04/29/1961 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 1 □ M 27 F Director 50 New York 139-56-2604 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 √2 Yes 2 □ No Director Harford Havre de Grace Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of 305 Squaw Court 21078 Funeral America 14 Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married þ 1 ☐ Yes 2√2 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Civil Service Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Frank Daly Pages 1 and 2 should or other traumatic Lillian Hoffman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21078 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health as
Important: If Item 27 Is
any injury or other trau Thomas Masterson (husband) 305 Squaw Ct., Havre de Grace, Maryland ltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West CHester, RA Ferris &Co.Inc.04/30/2012 Pennsylvania 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Signature of Funeral Sorvice Lights e 123 S. Washington St Havre de Grace, MD 23a. Part 1. Enter the Lease, or complications that caused the death. Do not enter the mode 4 dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause o Leach line. Immediate Cause (Final **Physician** ance disease or condition resulting in death) /Medical Due to (or an a continue of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of): if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be exect Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Onknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Vital 2 1 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifies 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 I Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To of funeral 27. Man of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 N atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🖳 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifie

30. Name and address pt

0

ho completed gause of death (Item 23a) (Type

10039855

FAURE DE GRACE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 2:52PM 4 28 2012 . Medical Odus Andrew Moore Jr 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mallard Bay Care Center Dorchester Cambridge 7. Age (In yrs. last birthday 8. Date of Birth If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Days Hours Min. Director 220-32-1761 1 ★ M 2 □ F 3-15-1935 MD Usual Residence of Decedent shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ler must be notified 1 Yes 2 No Cambridge Dorchester MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21613 5715 Green Cove Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Medical Examiner Armed Forces Black, White, etc. ö þ 1 Never Married 2 X Married 1 Yes 2 X No If Yes, Give Year or Dates. Saltimore, Maryland 21215-0036 1 Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) it of Health and Mental Hygiene.

If item 27 is marked other than or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Customer Service Rep Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alta Jones Odus Andrew Moore Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5715 Green Cove Rd. Cambridge, MD. 21613 Mildred Moore/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1  $\square$  Burial 2  $\bigcirc$  Cremation 3  $\square$  Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Midshore Cremation 5-2-2012 Cambridge, MD 21. Signature of Funeral Service Licensee 308 High St. Newcomb and Collins F.H.Cambridge, MD21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ neumoni A weeks disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) the burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) igned by the at be detached for g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy page 2 within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X10 Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 dursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1—Ratural injury 5 Pending Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation in my policies. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ the only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) Prable St (Aubric) 4 30. Name and address of person who Registrar's Signature APR 3 0 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Ralph wbert 0236 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Swanten If Under 24 Hrs. Min. Garret 26 Cemeters 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 220-36-6582 Director North Carolina 2/24/1927 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show event, the Medical Examinar must be notified at 1 □Yes 2 No Director MD Garrett Swanton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 death with 23a 21561 U.S.A. 26 Cemetery Hill Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or incany injury or other traumatic event 1 Tyes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 € Married altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5 Carpenter Carpenters Union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wallace Sally ပ Needham McPhail 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dorothy McPhail/ Wife Cemetery Hill RD., Swanton, MD 21561 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 4/25/2012 Swanton, Maryland Mt 22. Name and Address of Facility Newman Funeral Homes P.A. of Funeral Service License Kech Second St., Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that cused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Inknown disease or condition resulting in death) /Medical Due to (or as a consequence of): MKnown Examiner neimer! Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ned by the a detached f Division of Vital Records, P.O. 9 Unknown 9 Unknown sate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2- No 1 ☐ Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 5 Pending investigation 1 Natural 24 hours after death. Funeral Director; A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and tifle of certifie 29c. License number 00

State Registrar 30. Name and address of person

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dorothy Gertrude Marsh 8:45 A M Medical <u>April</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Egle Nursing and Rehab Center Lonaconing Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, 1 □ M 2 😾 F 90 Months Days Hours Director 232-26-3644 June Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Allegany Westernport MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21562 105 Roosevelt St. United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 K No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: white Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Paper Manufacturer Lab Technician 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bessie Rohrbaugh Robert Keplinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sondra Mroz/daughter 10248 Aviary Drive, San Diego, CA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/28/2012 Westernport Maryland 4 ☐ Donation 5 ☐ Other (Specify) Philos Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home on Church St, <u>Westernport</u>, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician ALZHEIMER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death
Unknown Month 2 M No Yes Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? nours after death.

neral Director: After this or
dilled in by the funeral dire ျှ Other: 2 🔽 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated з 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D2690 Hudha

Registrar

State

31. Date filed (Month, Day, Year)

APR 27

DHMH 17 Rev 7/2009

Dr. Harjit Sidhu, 925 Bishop Walsh DR., Cumberland, MD 21502

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Josephine Michaels Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WM Regional Medical Center Allegany Cumberland Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 3 1933 If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 220-28-9788 Days Hours **Director** 79 1 🗆 M 2 🔀 F Maryland Usual Residence of Dec 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 28a-f MD Allegany Barton 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 19023 North Eutaw St. 21521 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, an "natural", or ite Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: Completed 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Housework Homemaker unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Raymond Wilson Hazel McKenzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal Leap/daughter 19028 Water St, Barton, Maryland 21521 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ō Burial 2 Cremation 3 Removal from State <del>=</del> 5 Department of Important: If any injury or once. 04/27/2012 Barton, Maryland Laurel Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) husercapric resonator Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the I attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ģ Month Day Year Pregnant at time of death should be detached 9 Unknown q 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has performe 2 N 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes မ 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 5 Pending work? 1 \sum Yes 2 \sum No Natural injury the f Accident Suicide Investigation Director: 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland 12500

State Registrar 31. Date filed (Month, Day, Year) APR 2 5 20 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

06:05A

10d. Inside City Limits

Interval Between Onset and Death

Day

4,17,12

Year

1 X Yes 2 No

DHMH 17 Rev 06-2011

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Dr. Ardallan Enkeshafi,

31. Date filed (Month, Day, Year)

**APR 17** 

68455

12500 Willowbrook Road, Cumberland, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 20<u>12</u> Physician/ April Delbert 25 Myers 9:27 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Oxon Hill Prince George's Samaritan House Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Hours 1 x xM 2 □ F 85 10/27/1926 302-14-3357 **Director** Ohio Usual Residence of Decedent 28a-f shov 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Oxon Hill 1 Yes 2XXNo Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 Careybrook Lane 20745 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2XX Married Completed by Baltimore, Maryland 21215-0036 1x XYes 2 If Yes, Give 2 No 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. WW II Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant. If item 27 is marked other than "naturury or other traumatic event, the Medical ury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 years College (1-4 or 5+) Vice President Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Vancil Μ. Myers Pearl Starkey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Anne Myers / Wife 304 Careybrook Lane Oxon Hill, Maryland 20745 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Kalas Crematory permit. Page 1 Department of Important: If it any injury or o 1 Burial 2013 Cremation 3 Removal from State 4/28/2012 4 ☐ Donation 5 ☐ Other (Specify) Edgewater, Maryland Signature Fur ral Service Lice e 22. Name and Address of Facilit George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician cancer una Medical resulting in death) Due to (or as a conseq coof) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death detached the 9 Unknown g Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagr 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending X Natural . latural

Accident

Suic work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier 🎇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29d. Date signed (Month, Day, Year) 00052999 140 20735 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Drive G-06 CLINTON

State Registrar 31. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

10403

RAHIMIANMO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 SEYED Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner NURSING MANOR 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Director 30 IRAN show 10c. City, Town or Location 10d. Inside City Limits at Director notified 28a-f HAGERSTOWN 1 Tyes 2 No MD WASHINGTON o 10g. Citizen of What Country? must be 23a Completed by Funeral DRIVE IRAN . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner or i 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: WHITE 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) y/Secondary (0-12) College (1-4 or 5+) DISTRIBUTOR PHARMACEUTICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ၉ HOSSIEN MIRDAMADI NOT KNOWN ABDOL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON 11300 EASTWOOD DR. HAGIERS TOWN MD 21742 MIRDAMADI 20b. Place of Disposition (Name of cemetery, crematory or other place)
ALFIRDAUS MEMPLEN 0a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/23/12 FREDERICK, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ADEN MUSLIM FUNERAL SER 1242 EASY T. WCOOBRIDGE VA. 22191 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the di Immediate Cause (Final ive tory Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Be Completed by Physician/Medical Ele Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: ٩ 4 Augring Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 24 hours after death Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and file of permier Carl D354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1122 OPAL CT. HAGERSTOWN MD 21740 31. Date filed (Month, Day, Year)
APR 2 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Julius Raymond 6:30 P M Morse 04 18 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Prince George's Cheverly . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min 04/02/1919 **Director** 578-14-0065 1 🗶 M 2 🗆 F 93 Maryland Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD Prince George's Upper Marlboro 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15308 Marlboro Pike 20772 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married . Page 1 and 2 should be filed within 72 hours after of menth of Health and Mental Hygiene.
Then If item 27 is marked other than "natural", or jury or other traumatic event, the Medical Example into the other traumatic event, the Medical Example. þ Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🗶 No Specify: Black Completed 3 Widowed 4 Divorced Year or Dates. 1944 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Servant Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Julius Morse Martha Crowdy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Havana Morse/Wife 15308 Marlboro Pike Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 04/25/2012 | Cheltenham, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 the 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ ρ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown ate has been signed by the a page 2 should be detached t g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law 124 hours after death.
Funeral Director: After this certificate has t autopsy perfor death? No Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital No. Other: 1 Yes 2 ၉ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Date of injury (Month, Day, Year) r of Death 28b. Time of Mann 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-03085 State of Maryland / Department of Health and Mental Hygiene Wendy Gaynelle Myers 2012 14971 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 20, 2012 1622 hrs **Medical Examiner** Gaynelle Myers Wendv 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death La Plata Charles Civista Medical Center If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Director Country) 218-96-6130 1 M 05-31-1965 VA XXF 46 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No MD CHARLES WALDORF 28a-f show Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she
injury or other transmatic event, the Medical Examiner must be notified at once Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1144B HERITAGE PLACE 20602 U. S. A. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 Married 2 X No Yes 1 Yes 2 X No specify: 4 Divorced If Yes, Give Year Specify: WHITE 3 Widowed á 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) DISABLED Disability 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WILLIAM MAY MYERS JR. MARJORIE LEE MILLER 19a. Informant's Name/Relationship (Type, Print ) FATHER-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM M. MYERS JR. 144B HERTTAGE PLACE WALDORF, MD 20602 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition APRIL crematory or other place) 1 Burial 2 XCremation 3 Removal from State ATLANTIC CREMATORY 24,2012 GLEN BURNIE, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service Lice 5635 WASHINGTON AVE., LA PLATA, MD Zoa. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Sudden Unexpected Death In Epilepsy Immediate Cause (Final disease £xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): eauss. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and tran Physician/Medical  $\mathbf{x}_{AMENDED}$  16b, 23a, 27, per me, g928 6-8-12 sm X UNPENDED use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ğ Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed' death? page 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 Other:

Nursing Home 5 Residence 6 Other: DOA After this 1 V Yes 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No 5 Pending Director: d in by the f 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) determined 24 hours a Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

completely

30 Name and address of person who completed cause of death (Item 23a) ssistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Russell Alexander MD. State 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

29c. License number

OCME

29d. Date signed (Month, Day, Year)

April 21, 2012

Registrar

|   |                      |  | Plea                        | se Type or Pr  |  |                                      |   |                                | _                                  |                        | _                         | jible.           |   |
|---|----------------------|--|-----------------------------|--|--|--------------------------------------|---|--------------------------------|------------------------------------|------------------------|---------------------------|------------------|---|
|   | -                    | For State  |                             | State of N   | larylan                                      | · ·                                  | artment of F<br>rtificate of D                              |                                |                                    |                        | -                         | 112              | 11.972  |
|   | ,                    | Registrar  1. Decedent's Name  | e (First, Middle,           | Last)  |  |                                      | timoato or z  | -                              | 2. Date of Dea                     | ath                    |                           |                  | 3. Time of Death                              |
| Physicia<br>Medic   | al                   |  |                             | Narayanan  |  |                                      |   |                                | April                              | 19                     |                           | 2012             | 12:59 А м                                     |
| Examin  | er                   |  |                             | give street and number) ntist Hospital   |  |                                      | Rockvi  | r Location of Death<br>11e     |                                    |                        | c. County<br><b>Montg</b> |                  |   |
| Funeral<br>Director   |                      | 5. Social Security Nu<br>212–29–658  | 7                           | 6. Sex<br>1 X M 2 D F 7. As  | ge (In yrs. la<br>88                         | ast birthday)<br>Yrs.                | If Under 1 Year<br>Months Days                              | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>Januar y       | ь<br>5 <sup>ү</sup> тс | 24                        |                  | nplace (State or Foreign<br>ntry) India       |
| and<br>show<br>Lat  | or                   | Usual Residence of<br>10a. State   | Decedent<br>10b. County     |  | 10c. City                                    | y, Town or Lo                        | ocation   |                                |                                    |                        |                           |                  | 10d. Inside City Limits                       |
| Maryl<br>28a-f<br>ootified  | Jirect               | MD   | Montgor                     | nery   | Gar  | ithersb                              |   |                                |                                    |                        |                           |                  | 1X Yes 2 □ No                                 |
| with the  | Funeral Director     | 10e. Street and Num 16400 Apac   |                             |  |  |                                      | 10f. Zip Code<br>20878                                      |                                |                                    | 10g. C                 | itizen of t               | What Cou         | intry?  |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.                                  | by                   | 11. Marital Status  1  Never Marri 3  Widowed  |                             | 12. Was Decedent Armed Forces? 1  Yes 2 If Yes, Give Year or Dates.              | Ever in U.S                                  |                                      | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 🙀 No | an, Mexican, Puerto            | ecify Yes or No-<br>Rican, etc.)   |                        |                           | ck, White        | can Indian,<br>etc.<br>sian                   |
| "natul  | Completed            | (Spe   |                             | t's Education<br>st grade completed)   |  | (Give                                | dent's Usual Occup<br>kind of work done o                   | during most of worl            | king                               |                        | Kind of B                 |                  | ndustry<br>s Department                       |
| within 7<br>giene.<br>er than<br>the M  |                      | Elementary/Second 12   | onday (0-12)                | College (1-4 or  | 5+)  | Sal                                  | OO NOT use retired)<br><b>es</b>                            |                                |                                    |                        | lian A                    |                  | s repair utient                               |
| id be filed v<br>Mental Hyg<br>arked oth  | To Be                | 17. Father's Name (F   |                             |  |  |                                      |   |                                | ne (First, Middle, I<br>Kottappura |                        | n Surnam                  | e)               |   |
| 2 shou<br>th and<br><b>27 is m</b><br>traum   | - 25                 | 19a. Informant's Na  |                             | ip (Type, Print)<br>Vinod/Son  |  |                                      | ing Address (Street a                                       |                                |                                    |                        |                           | State, Zip       | Code)   |
| of Heal<br>of Heal<br>fitem   |                      | 20a. Method of Disp  | osition                     | 3 Removal from State   | 20b. P                                       | lace of Disp                         | osition (Name of<br>matory or other place                   | ce)                            | Date                               | 20c.                   | Location                  | -                | Town, State                                   |
| it. Page<br>rtment<br>rtant; I<br>njury o   | -                    | 4 Donation   | 5 Other (S                  | pecify)  | At1  | antic C                              | rematory  | 4/21/                          | 2012<br>ock Funer                  |                        | en Bu                     | rnie,            | MD  |
| permi<br>Depar<br>Impo<br>any ir  | - 8                  | 21. Signature of Eur   | neral Service Li            | Censee /   |  | 2                                    | 2. Name and Addres 7601 Sandy                               | Spring Roa                     |                                    |                        |                           | 7                |   |
| Physician/  |                      | shock, or hear<br>Immediate Cause (<br>disease or conditio                               | rt failure. List o<br>Final | complications that cause<br>nly one cause on each lin                            | ie.  | S1 2                                 | ter the mode of dyin  | ig, such as cardiac            | or respiratory arre                | est,                   |                           |                  | Approximate Interval Between Onset and Death  |
| Medical<br>Examiner   |                      | resulting in death)  |                             | Due to (or as  | a consequ                                    | uence of):                           | 1   |                                |                                    |                        |                           |                  |   |
| ed<br>nsit  | Examiner             | Sequentially list con<br>if any, leading to im<br>cause Enter Union<br>Cause (Disease or | nmediate                    | b. Due to (or as   | a consequ                                    | uence of):                           |   |                                |                                    |                        |                           |                  |   |
| e executed<br>cian and<br>urial-transi  |                      | that initiated events<br>resulting in death) I   |                             | C. Due to (or as   | a consequ                                    | uence of):                           |   |                                |                                    |                        |                           |                  | , <del>.</del>                                |
| icate by<br>physic<br>is the b  | ledic                |  |                             | d  |  |                                      |   |                                |                                    | _                      |                           |                  |   |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit | by Physician/Medical | IF FEMALE;<br>23b. Was decedent<br>in the past 12 r<br>1 Yes 2 9<br>Unknown              | months?                     | 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown                     | 2 🗀 Feta<br>at time of c                     | aldeath 3                            | Ectopic pregnanc<br>Other (specify)                         | су                             |                                    | d                      |                           | nte of deliventh | very<br>Day Year                              |
| quires that t<br>en signed b<br>uld be deta   | ed by P              | Part II. Other signif  | icant conditio              | ns contributing to death   | but not res                                  | ulting in the                        | underlying cause giv  | ven in Part I.                 |                                    |                        |                           |                  | the cause of death?                           |
| The law rec<br>cate has bee<br>page 2 sho   | Completed            |  |                             |  |  |                                      |   |                                | 24a. Was a autop perfor 1  Yes     | sy<br>rmed?            |                           |                  | opsy findings available ompletion of cause of |
| iclan:<br>certific<br>rector,   | Be                   | 25. Was case referred examiner?  | ed to medical               | Hospital:  |  | ,                                    | Oth   | lace of Death (Chec            | ck only one)                       |                        |                           |                  |   |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,  | cate: To             | 27. Manner of Death  1 A Natural 2 Accident  |                             | 28a. Date of inj<br>(Month, Da   | ury  | ER/Outpatie<br>28b. Time o<br>injury | of 28c. Injury  | 4 □ Nursing H<br>y at          | ome 5 Resid                        |                        |                           |                  | ýy)   |
| al or Atter<br>s after dea<br>Il Director<br>ed in by the   | Certificate;         | 3 Suicide<br>4 Homicide  | 6 Could r<br>determi        | not be 28e. Place of In  | jury - <b>A</b> t ho<br>tc. (S <i>pecify</i> |                                      | reet, factory, office                                       |                                | 28f. Location (Si<br>City or Town  |                        |                           | er or Rura       | al Route Number,                              |
| the Hospit<br>nin 24 hour<br>the Funere   | Medical              | (Check 2<br>only one) 3  | ☐ Medical E                 | Physician: To the best o<br>xaminer: On the basis of<br>Nurse Practioner: To the | examinatior                                  | n and/or inve                        | stigation, in my opinio                                     | on, death occurred a           | at the time, date ar               | nd plac                | e, and du                 | e to the ca      | ause(s) and manner stated.                    |
| To with   |                      | 29b. Signature and   | title of certifier          | + Gast   |  | B                                    | 29c, Licenso  | e number<br>44559              | 2                                  | 29d. D                 | ate signe                 | d (Month,        | Day, Year)                                    |
| 44  |                      | •  | SCOTT                       | 1 4  | ecdo   | nan v                                | 2) 990  | 1 Medica                       | al Cente                           | rl                     | )rive                     | Roc              | 20850<br>Kuille MD                            |
| Stat<br>Registra  |                      | 31. Date filed (Monti  | APR 2                       |  | rar's Signat                                 | ture <b>d</b> .                      | park  |                                |                                    |                        |                           |                  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 14973 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ 9:25 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Harwood Mandrin Inpatient Care Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Days Hours Director 1**X**□ M 2 □ F 027-07-9814 95 June 29, 1916 Massachusetts "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b, County 10c. City, Town or Location Director 1 X Yes 2 No Maryland Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21035 USA 3960 Birdsville Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Ayes 2 19944If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Midowed 4 ☐ Divorced Completed Year or Dates. 1946 White Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Leather Tanner & Salesman Leather 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked ot Israel Ossoff Annie Shochet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Martha Ossoff Blaxall/ Daughter 3960 Birdsville Road Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date T o X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/27/2012 | Peabody, MA 4 Donation 5 Other (Specify) Maple Hill Cemeterv 22. Name and Address of Facility Robert E. Evans Funeral Home Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death HEIMER'S Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) MANDRIN 1 ☐ Yes 2 🗷 No 9 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28h Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after deau...

To the Funeral Director. After the funeral part of the work 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \*\*Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO 0 14774 445 Defense Huy Annagelis, MO 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHID M. O 32. Fegistrar's Signature Date filed (Month) State 5 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 10:15 P<sup>M</sup> Ethel Jane Poppe 04 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Ceci1 Union Hospital E1kton Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 XF Months Days Hours Min (Month, Day, Year) 5/17/1947 Country) Director .65-38-8821 64 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits death with the Maryland 10c. City, Town or Location Director 1 ☐ Yes 2 X No Chesapeake City MD Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 106 Woodstock Drive 21915 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican. etc.' Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Department of Corrections State of DE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F Department of Health and Menta-Important: If item 127 is marked any injury or other \*\*\* Edward Gresmer Ethel Terrezzi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Poppe - husband 106 Woodstock Drive, Chesapeake City, MD 21915 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 4/19/2012 Delaware Veterans Cemi-Bear, DE of uneral Service Licen 22. Name and Address of Facility R.T. Foard Fuenral Home, PA 259 East Main Street, Elkton, MD 2192 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NDOMETRIAL disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year ed by the a Unknown 9 Unknown Division of Vital Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown been signatures Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed 2 🗌 No Yes 2 X 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No death. Accident Investigation 6 Could not be Director: / 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Cartifying Nurse Practioner To the best of my knowledge at the time date and clane and due to the o 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 00062190 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ KHAN

DHMH 17 Rev 7/2009

State Registrar

5

HWY, SUITEA, CHESAPEAKE CITY

MD21915

HERMAN

32. Registrar's Signature

AUGUSTINE

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $2012^{\text{Year}}$ Day Physician/ Month 18 Charles Richard Peek 2:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 Smith Creek Assisted Living Warwick 8. Date of Birth (Month, Day, Year 2/12/192 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 □ F Hours Director 85 233-36-8322 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 21921 130 Continental Drive Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Never Married 2 K Married ò þ X Yes 2 No 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: "natural", White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Engineering Engineer other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked or ည Thelma Davisson Percy Leon Peek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Continental Drive, Elkton, MD 21921 130 Ann K. Peek - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State 4/22<sup>Date</sup>012 Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) .T.Foard Funeral Home. Rising Sun, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, PA <u> 259 East Main Street, Elkton, MD 2192</u>] 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final DEORPENSATED Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine n any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a conscius that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 ☐ Yes ∠ ☐ g ☐ Unknown q | Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours after death. To the Funeral Director. After this certificate has I completed filled in by the funeral director, page 2  $\epsilon$ 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 4/18/12 DO 65733

STIVA

State Registrar 126 A

EAST

12 CKTON, MD

21921

HIGH STROOT,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAO

NARMANA

31. Date filed (Month, Day

V. PULA

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  |              | for State   | State of Man   |  |  |   | d Mental H                               | ygiene 0                                   | 10                                     | 1107                        |
|--|--------------|---|--|--|--|---|--|--|--|-----------------------------|
|  |              | Registrar  1. Decedent's Name (First, Middle, La.                             | 24)  | Cer  | tificate of I  | Death                                   |  | Reg. No. 2                                 | 012                                    | 1491                        |
| Physicia<br>Medic  | cal          |   | Beatrice Ida   | Rosenber                                     | ıg   |   | 2. Date of E<br>April                    | D  | 2 <sup>V</sup> ear 2 3. т              | ime of Death 5:00p M        |
| Examin   | er           | 4a. Facility Name (if not institution, give                                   |  |  | 4b. City, Town, o  |   |  | 4c. County                                 |  |                             |
| Funeral  |              | 10912 Lamplio  5. Social Security Number 6. S                                 |  | yrs. last birthday)                          | If Under 1 Year  | Potomac                                 |  |  | lontgome                               | _                           |
| Director   |              | 095-20-1167   | □ M 2 12 F   |  | Months Days  | Hours Mi                                |  |  | 9. Birthplace (S<br>Country)           | tate or Foreign             |
| d d  | _            | Usual Residence of Decedent   |  | 86 Yrs.                                      |  |   | March                                    | 26,1926                                    | New                                    | York                        |
| ırylan<br>I-f sh<br>ied a  | cto          | 10a. State  |  | c. City, Town or Loc                         | ation  |   |  |  | 10d. Ins                               | ide City Limits             |
| ne Ma<br>or 28a<br>notif   | Director     | Maryland Montgo   | mery   |  |  | Potomac                                 |  |  | 1 [                                    | Yes 2X No                   |
| nd 21215-0036<br>filed within 72 hours after death with the Maryland<br>al tygiene.<br>I other than "natural", or items 23a or 28a-f show<br>vent, the Medical Examiner must be notified at  | Funeral      | 10912 Lamplig   | ihter Lane   |  | 10f. Zip Code  | 20854                                   |  | 10g. Citizen of W                          | /hat Country?                          |                             |
| deatl  |              | 11. Marital Status  | 12. Was Decedent Ever<br>Armed Forces?   | in U.S. 13. W                                | as Decedent of Hi<br>Yes, specify Cuba                     |   | Specify Yes or No                        | 14 Bace                                    | - American India                       |                             |
| after after all", or xami  | Completed by | 1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced                        | 1 Yes 2 X No   |  | res, specify Cuba<br>□ Yes 2 🏞 No                          |   | rto Rican, etc.)                         | Black                                      | k, White, etc.                         | ш,                          |
| hours  | ete          | 15. Decedent's Ed   | Year or Dates.   |  |  |   |  | Specify:                                   | whi                                    | ite                         |
| 215<br>in 72<br>is an "r   | mo           | (Specify only highest gra   | de completed)  | (Give kii                                    | nt's Usual Occupa<br>nd of work done o<br>NOT use retired) | ation<br>Iuning most of w               | o <i>rki</i> ng                          | 16b. Kind of Bu                            | siness/Industry                        |                             |
| nd 21;   |              | Liementary/Secondary (0-12)   | College (1-4 or 5+) <b>5+</b>  |  | Dental H   | luaionis                                | t  |  | Dentistr                               |                             |
| ind<br>filed<br>tal Hy<br>ed oth   | To Be        | 17. Father's Name (First, Middle, Last)                                       |  |  |  |   |  | , Maiden Surname)                          | venusvi                                | -9                          |
| Maryland 21215-0036<br>2 should be filed within 72 hours after<br>th and Mental Hygiene.<br>27 is marked other than "natural", or<br>traumatic event, the Medical Exami  |              |   | h Berkowitz  |  |  |   |  | Abelowi                                    | tz                                     |                             |
| Mal<br>2 sho<br>th and<br>7 is r   |              | 19a. Informant's Name/Relationship (Ty  |  | 19b. Mailing                                 | Address (Street a  | n <i>d Number</i> or R                  | ural Route Numb                          | er, City or Town, Sta                      | ate, Zip Code)                         |                             |
| and and the least term 2   |              | Diane Rosenberg -  20a. Method of Disposition                                 |  | 7821   | Oldchest   | er Road                                 | ,Bethesd                                 | la, Marylai                                | nd 20817                               |                             |
| Baltimore, Maryland 2 permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once.   |              | 1 X Burial 2 Cremation 3 X  | Removal from State   | b. Place of Disposit<br>cemetery, crema      | tory or other place  | e)                                      | Date                                     | 20c. Location - 0                          |  |                             |
| altir  |              | 4 Donation 5 Other (Specify 21. Signature of Funeral Service License          |  | ing David                                    | l Mem Gro  | ins 04/                                 | 23/2012                                  | Falls Ch                                   | urch, V                                | irginia                     |
| Ba<br>permi<br>Depa<br>Impo<br>any ir  |              | > MBhotaly  | O MO152  | 4 118  | 1ame and Address   | <sup>s of Facility</sup> H.<br>Hampshin | ines-Rin                                 | aldi Fund                                  | PAGE Ham                               | O THO                       |
|  |              | 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on | ications that caused the c   | death. Do not enter t                        | he mode of dying   | , such as cardia                        | or respiratory ar                        | rest,                                      | Approx                                 |                             |
| Physician/   |              | Immediate Cause (Final disease or condition                                   | Pneumo   | ria  |  |   |  |  | Interval                               | Between<br>and Death        |
| Medical<br>Examiner  |              | resulting in death)   | Due to (or as a cons   |  |  |   |  |  |  |                             |
|  | <u>.</u>     | Sequentially list conditions,   | Dehydro  Due to (or as a cons  | rtion  |  |   |  |  |  |                             |
| g _ g  | Examiner     | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Malnut   |  |  |   |  |  |  |                             |
| execunity and and and and and and and and and and  | ĭ            | that initiated events resulting in death) Last                                | Due to (or as a cons   |  |  |   |  |  |  |                             |
| ision of Vital Records, P.O. Box 68760  Attending Physician: The law requires that the death certificate be executed ar death.  stoer. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burners:  | 200          |   | ı  |  |  |   |  |  |  |                             |
| 68760<br>rertificate biding physic   |              | F FEMALE:   |  |  |  |   |  |  |  |                             |
| Box 68 death certifi   |              | 23b. Was decedent pregnant in the past 12 months?                             | Bc. If yes, outcome of pred<br>1 Live Birth 2 F                                      | etal death 3 F                               | ctopic pregnancy   |   |  | 23d. Date                                  | of delivery                            |                             |
| P.O. Bc. hat the dealed by the a detached f  | 25           | 1 Yes 2 X No  | 4 Pregnant at time 9 Unknown   | of death 5 0                                 | ther (specify)   |   |  | Month                                      |  | Year                        |
| P.O. that the ned by the detach  |              | Part II. Other significant conditions con                                     | tributing to death but not   | resulting in the unde                        | rhying on use sixes  | a in Dunt I                             |  |  |  |                             |
| S, P.(   | 2<br>2,      | Alzheimer's De  |  | rosaling in the dilde                        | arrying cause giver  | rin Parti,                              | 1 -                                      | bacco use contribu                         |  |                             |
| ords   |              |   |  |  |  |   | 1 🗆 )                                    | ′es 2 🗶 No 3                               | Probably 4                             | Unknown                     |
| Reco   |              |   |  |  |  |   | 24a. Was a<br>autop                      | sy prio                                    | e autopsy finding<br>r to completion o | gs available<br>of cause of |
| ictal Resident The certificate rector, pag   |              | 5. Was case referred to medical   |  |  | 00.5   |   | perfor 1 Yes                             |  | Yes 2 No                               |                             |
| Physici<br>Physici<br>this cer<br>al direc   |              | examiner? 1 Yes 2 X No  | spital:  | ☐ ER/Outpatient 3                            | Othor  | e of Death (Chec                        |  |  |  |                             |
| Division of Vital Records, all or Attending Physician: The law requires as after death.  If Director After this certificate has been signed in by the funeral director, page 2 should be Certificate: To Be Completed  |              | 7. Manner of Death 1 🗓 Natural 5 🗌 Pending                                    | 28a. Date of injury<br>(Month, Day, Year)  | 28b. Time of                                 | 28c. Injury at   | 4 □ Nursing H<br>t                      | ome 5 X Reside                           | ence 6 Other (Sow injury occurred          | Specify)                               |                             |
| Sion of Attending P reath. ctor: After toy the funerally t |              | 2 Accident Investigation 3 Suicide 6 Could not be                             | (month, bay, rear)   | injury                                       | work?<br>1 ☐ Ye  | s 2 🗆 No                                |  | w mary occurred                            |  |                             |
| Division of all or Attending F a fler death. I Director: After t d in by the funer. Certificate:   |              | 4 Homicide determined   | 28e. Place of Injury - At building, etc. (Spec                                       | home, farm, street, i                        | actory, office   |   | 28f. Location (St.                       | reet and Number of                         | r Rural Route Nur                      | mber,                       |
| Hospital 24 hours Funeral I  | -            | 9a. Certifier 1 X Certifying Physic   |  |  |  |   | City or Town                             | ,  |  |                             |
| Divis To the Hospital or At within 24 hours after C To the Funeral Direct completely filled in by  | '            | (Check 2 Medical Examiner only one) 3 Certifying Nurse I                      | an: To the best of my kno<br>On the basis of examinat<br>Practitioner: To the best o | wledge, death occu<br>ion and/or investigati | rred at the time, d<br>on, in my opinion,                  | ate and place, a<br>death occurred a    | nd due to the cau<br>t the time, date an | use(s) and manner a<br>d place, and due to | is stated.<br>the cause(s) and n       | nanner stated               |
|  |              | b. Signature and title of certifier   | Practitioner: To the best o  | i my knowleage, dea                          | 29c. License nu  | arrio, date and pi                      | ace, and due to the                      | e cause(s) and mann                        | er as stated.                          |                             |
| 10   |              |   | - : **   |  |  | 35370                                   |  | 9d. Date signed <i>(M</i>                  |  | 12-                         |
|  | 30           | . Name and address of person who com  |  |  |  |   |  |  |  |                             |
| State  | 31           | Jan Bachowski, M.  Date filed (Month, Day, Year)                              | <i>V.</i> , 11125 R  | ockville                                     | Pike, Ro   | ckville                                 | , Maryla                                 | nd 20852                                   |  |                             |
| Registrar  | L            | APR 2 6 2012  | Senton A   | ature factor                                 |  |   |  |  |  |                             |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g92/ 5-24-12 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April Estelle S. Riemer 2<sup>Year</sup> 2 0031 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery Social Security 8091 If Under **Funeral** 7. Age (In yrs. last birthday 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days **Director** 214-32-<del>1570</del> 1 M 2 X F 77 09/21/1934 Maryland 28a-f show 10a. State 10c. City, Town or Location notified at Director 10d. Inside City Limits Silver Spring Maruland Montgomery 1 Yes 2 X No 10e. Street and Number items 23a or ner must be n ō 10f. Zin Code 10g. Citizen of What Country? Funeral 2510 Fairland Road 20904 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, r than "natural", or iter the Medical Examiner Armed Forces Black, White, etc 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Completed 3 X Widowed 4 □ Divorced Specify Year or Dates Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. ot**her than** " Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Charles Stephens Flossie Newton and l 19a. Informant's Name/Relationship (Type, Print) item 27 P.O. Box 302, Fulton, Maryland 20759 Sharon Isaac - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place)
Potomac Baptist
Church Cemetery 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/30/2012 King George, Virginia 21. Signature of uneral 3 or vir e censer 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. MUDZOG <u> 11800 New Hampshire Ave.,Silver Spring,MD 20904</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Onset and Death disease or condition resulting in death) Sepsis 24 Hours Medical Due to (or as a consequence of): Examiner Acute Myelogenous Leukemia 1 Year Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number D35996 April 25, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., Burrell, 2730 University Blvd., #400, Wheaton, Maryland 20902 . Registrar's Signat State 2 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Grace Janet Routzahn 2012  $P^{\mathsf{M}}$ April 3:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Homewood at Crumland Farms Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. **Director** 189-24-5097 84 1 □ M 2 🏋 F Yrs Feb.17, 1928 New York Usual Residence of Decedent 28a-f show 10b. County an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 📈 No Maryland | Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7407 Willow Road 21702 USA · death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 X Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working nd Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph F. Whittum Florence Curtis and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8701 Berwick Place North, Ijamsville, MD 21754

7407 Willow Road, Ijamsville, MD 21754 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau <u> Daryl Routzahn / Son</u> Baltimore, od of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Olivet Cemetery : 4/17/2012 Frederick, Maryland 21. Signatural of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1 Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MULTIPLE MYELDMA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical death certificate be P.O. Box 68760 as the t IF FEMALE JSe a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the at Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director. After this certificate has completely filled in by the fineral Attention autopsy 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tyes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b 29d. Date signed (Month, Day, Year) 006243

5 State Registrar

31. Date filed (Month, Day, Year) APR 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , ru) 32. Registrar's Signature

TIDRIUT, FORDTHE, TO 21782

4/13/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

|                            |   | ı               | 1 - For<br>State<br>Registrar   | State of Maryland  | d / Department<br>Certificate   |   |  | ne 2012  | 2 14979  |
|----------------------------|---|-----------------|---|--|---|---|--|--|--|
|                            | Physicia<br>Medic   |                 | 1. Decedent's Name (First, Middle, Las<br>Alberta   | · _  | tolle   |   | 2. Date of Death<br>Month  | Day Year   | 3. Time of Death 0944 A M                      |
| - Wing                     | Examir  |                 | 4a. Facility Name (if not institution, give   | street and number)   | 4b. City, To  | own, or Location of Death   | h  | 4c. County of Deat   | h*   |
|                            | Funeral<br>Director   |                 | FeNINSUIA REGIONAL<br>5. Social Security Number 6. Se<br>220 - 26 - 1997 1                              | 7. Age (In yrs. la   | ast birthday) If Under 1<br>Months  | Year If Under 24 Hrs.<br>Days Hours Min.  | 8. Date of Birth (Month, Day, Yea  | 9. Birt  | hplace (State or Foreign untry)                |
|                            |   | 'n              | Usual Residence of Decedent  10a. State 10b. County   | , 04   | Yrs.  y, Town or Location   |   | May 22,  | 1929 M   | an land 10d. Inside City Limits                |
|                            | e Maryla<br>r 28a-f s<br>notified   | Director        | Maryland Somers   | .et  | Princess  |   |  |  | 1 X Yes 2 □ No                                 |
|                            | n with th   | Funeral [       | 11326 Greenwe   | od School R  | 10f. Zip C  | 31853   |  | Citizen of What Co   | untry?   |
| 9800                       | e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at   | 호               | 11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced                             | 12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates.  | If Yes, specify   | nt of Hispanic Origin? (Sp<br>y Cuban, Mexican, Puerto<br>No Specify:           | pecify Yes or No-<br>o Rican, etc.)  | 14. Race - Amer<br>Black, White<br>Specify: <b>B</b>               |  |
| 21215-0036                 | n 72 hou<br>e.<br>an "natu<br>Medical   | Completed       | 15. Decedent's Ec<br>(Specify only highest gra<br>Elementary/Secondary (0-12)                           | ducation<br>de completed)<br>College (1-4 or 5+)   | 16a. Decedent's Usual (<br>Give kind of work<br>life. DO NOT use re                     | done during most of wor.  | rking 161  | b. Kind of Business/   |  |
|                            | filed within<br>al Hygiene.<br>d other thai<br>event, the N   | Be Co           | 17. Father's Name (First, Middle, Last)   | College (1-4 or 5+)  | Labor   |   | me (First, Middle, Maid  | Cafeter  | ia   |
| Maryland                   | d b<br>Mer<br>ark   | J.              |   | nes  | Pitt.   | ALL   | erta .   | Jones  |  |
|                            | 2 sho<br>ith an<br>27 is<br>trau  |                 | 19a. Informant's Name/Relationship (Ty<br>Barbara William   |  |   | Green wood  |  | _  | Code)<br>Anne, MD, 21853                       |
| altimore,                  | 4. O 4- L   |                 | 20a. Method of Disposition  1   | Pamoval from State Ce.   | lace of Disposition (Name<br>emetery, crematory or othe<br>Wesley Ce                    | er place)   |  | C. Location - City or  |  |
| Balti                      | permit. Page<br>Department<br>Important: I<br>any injury o  |                 | 21. Signature A Funeral Service License   |  | 22. Name and  | Address of Facility   | nthony E.  | Ward   | F. H.<br>ne, MD, 2183                          |
|                            |   |                 | 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or                           | lications that caused the death.   | i. Do not enter the mode of   | of dying, such as cardiac   | or respiratory arrest,   | ncess An   | Approximate Interval Between                   |
| 5                          | Ph, sician/<br>Medical  |                 | Immediate Cause (Final disease or condition resulting in death)   | a.   | ence of):   | strate  |  |  | Onset and Death                                |
|                            | Examiner  | ıer             | Sequentially list conditions, if any, leading to immediate  | b. Except  Due to (or as a conseque  | alopathy  |   |  |  |  |
|                            | and<br>-transit   | Examiner        | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         | c. Due to (or as a conseque  |   |   |  |  |  |
| 260                        | icate be executed<br>g physician and<br>is the burial-transit   | edical E        | Last Last   | d.   | erice oij.  |   |  |  |  |
| Box 687                    | To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as to a suppletely filled in by the funeral director. | Σ∣              | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown                 | 23c. If yes, outcome of pregnant 1  Live Birth 2  Fetal 4  Pregnant at time of de 9  Unknown                                   | death 3 Ectopic pre   |   |  | 23d. Date of deli<br>Month   | very<br>Day Year                               |
| P.O.                       | s that the<br>gned by<br>be detac   |                 | Part II. Other significant conditions co  | ntributing to death but not resul  | ulting in the underlying cau  | use given in Part I.  | 23e. Did tobacc  | co use contribute to   | the cause of death?                            |
| ords,                      | require<br>been signature<br>should b   | Completed by    | Acute respira   | HOIG THILLIE   |   |   | 1  Yes   |  | obably 4 Unknown opsy findings available       |
| Rec                        | sician: The law is certificate has bilirector, page 2 s   |                 |   |  |   |   | autopsy<br>performed<br>1 Yes 2  | prior to c<br>death?   | ompletion of cause of<br>2  No                 |
| Vita                       | ysician<br>s certifi<br>directo   | To Be           | 25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{No} \) No                     | lospital:  | ER/Outpatient 3 DOA   | 26. Place of Death (Chec  | ok only one) ome 5 🗆 Residence   | 6 Other (Specie  | F.A.   |
| n of                       | nding Phy<br>tth.<br>: After thi<br>e funeral   |                 | 27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation                                       |  |   | lnjury at work? 1 ☐ Yes 2 ☐ No  | 28d. Describe how in   |  | <i>y</i> )                                     |
| Division of Vital Records, | within 24 hours after death. within 24 hours after death. To the Funeral Director. After this certific  | al Certificate: | 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of Injury - At hom<br>building, etc. (Specify)  |   | ffice   | 28f. Location (Street<br>City or Town, Sta                                     | ate)   |  |
| :                          | ne Hosp<br>in 24 hot<br>he Funei<br>pletely fi  | Medical         | 29a. Certifier (Check check only one) 1 Certifying Physical Examina (Check only one) 3 Certifying Nurse | cian: To the best of my knowled<br>er: On the basis of examination a<br>Practitioner: To the best of my                        | edge, death occurred at th<br>and/or investigation, in my<br>y knowledge, death occurre | e time, date and place, a opinion, death occurred a ed at the time, date and pl | and due to the cause(s<br>at the time, date and pla<br>lace, and due to the ca | s) and manner as sta<br>ace, and due to the cause(s) and manner as | ited.<br>ause(s) and manner stated.<br>stated. |
| _                          | Voith Con to to to to to to to to to to to to to  |                 | 29b. Signature and title of certifier   | troin  | 29c. Li   | cense number  | 29d.   | Date signed (Month,  | Day, Year)                                     |
|                            | they  |                 | 30. Name and address of person who co   | impleted cause of death (Item 2  | 23a) (Type, Print)  | branke T-   |  | 1  | 21012  |
|                            | Stat<br>Registra  | ~               | 31. Date filed (Month, Day, Year)  APR 2.6. 20  | Practitioner: To the best of my  Practitioner: To the best of my  mpleted cause of death (Item 2  12  32. Registrar's Signatur | b. back   | ,   | 5AL136   | oury mo  | 21007  |

DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Martha Jane Rei  |                 | S<br>1- For State<br>Registrar   | tate of Marylar   |                                      | ment of<br>ficate of   |                                 | l Menta                   |                                     | Reg. No.         | 201                          | 2   498  |
|--|-----------------|--|---|--------------------------------------|------------------------|---------------------------------|---------------------------|-------------------------------------|------------------|------------------------------|--|
| Physicia<br>Medical Exami  | in/             | Decedent's Name (First, Mide     Martha Jane   |   |                                      |                        |                                 |                           | 2. Date of De<br>Month<br>April 27, | ath<br>Day       | Year                         | 3. Time of Death<br>1242 hrs                     |
| inculoar Exami   |                 | 4a. Facility Name (if not instituti  |   | ber)                                 | 14                     | b. City, Town, or L             | ocation of D              | Peath April 27,                     | 4c, 0            | County of Death              |  |
|  |                 | Meritus Medical Cent  5. Social Security Number  |   | . Age (In yrs. last                  | hirthday)              | Hagerstown  If Under 1 Year     | If Under 2                | MHrs 8 Date of B                    |                  | ashington                    | hplace (State or                                 |
| Funeral<br>Director  |                 | 219-52-1323  | 1 M 2XXF  | 61                                   | Yrs.                   | Months Days                     |                           | Min. May 4                          | •                | Foreig                       |  |
| any  | ŀ               | Usual Residence of Decedent  10a, State 10b. County  |   | 10c. City, To                        | wn or Locati           | on                              |                           |                                     |                  |                              | 10d. Inside City Limits                          |
| ne Maryland<br>or 28a-f show<br>fied at once,  | ō               |  | shington  |                                      |                        | Williams                        | port                      |                                     |                  |                              | 1 Yes 2 No                                       |
| or 28a-  | Director        | 10e. Street and Number   | na Dand   |                                      |                        | 10f. Zip Code 217               | O.E.                      |                                     | 10g. Citize      | en of What Cour              |  |
| imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland men of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoor or other traumatic event, the Medical Examiner must be notified at once. |                 | 17217 Sterli 11. Marital Status  | 12. Was Deced   | lent Ever in U.S.                    |                        | s Decedent of Hisp              | panic Origin?             | ? ( Specify Yes or N                | 0- 14            |                              | can Indian, Black,                               |
| r death  | Funeral         | 1 Never Married 2 N  | 1 Yes   | es?<br>2XX No                        | _                      | es, specify Cuban,              |                           | uerto Rican, etc.)                  |                  | White, etc.                  | White  |
| ars afte   |                 | 3 Widowed 4 Di  15. Decedent's Education (Spe  | vorced If Yes, Give Year<br>or Dates:<br>ecify only highest grade | completed) 16                        |                        | Yes 2 No                        | specify:<br>on (Give kind | d of work done                      |                  | pecify:<br>nd of Business/li |  |
| 6<br>172 hou<br>nn "na<br>cal Ex   | Completed by    | Elementary/Secondary (0-12)  | College (1-4  | or 5+)                               | during mo              | ost of working life.            | DO NOT use                | e retired)                          |                  |                              |  |
| -003<br>I within<br>grene.<br>ther the   | E .             | 12.0 17. Father's Name (First, Middle  | 4   |                                      |                        | Editor                          | 8 Mother's N              | lame (First, Middle,                |                  | ok Publi                     | shing.   |
| D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica   | Be              | Charles Eli  | Reid  |                                      |                        |                                 | Nell:                     | ie Irene                            | Shi              | plev                         |  |
| ID 21<br>should<br>and Mer<br>77 is man  |                 | 19a. Informant's Name/Relation   |   |                                      |                        |                                 |                           |                                     |                  |                              | Zip Code 21783                                   |
| B, MD and 2 sho Health and item 27 is  | ŀ               | 20a. Method of Disposition   | now-Cousin  |                                      | ce of Disposi          | tion (Name of cem               |                           | Smithsbur<br>Date                   |                  | cation - City or             |  |
| MOF<br>Pages  <br>ent of ]<br>r other  |                 | 1 XXBurial 2 Cremation 4 Other 5   |   |                                      | matory or oth<br>nlawn | <sub>erpiace)</sub><br>Mem. Par | k Ma                      | ay 4,2012                           | Wil              | liamspo                      | rt,Maryland                                      |
| Baltimore, MD permit. Pages 1 and 2 shu Department of Health and Important: If item 27 is injury or other traumat  | Ī               | 21. Sr nature f Funeral S  | Lixinsae  | <u> </u>                             | 17070775               |                                 |                           | ome, F.A<br>ague St.W               |                  | msport.                      | MD 21795   |
| Physician  | - 54            | 23a. Part I. Enter he disease, o   | r complications that cau  | sed the death. Do                    |                        |                                 |                           | -                                   |                  | _                            | Approximate Interval                             |
| Medical<br>Examiner  | 174             | failure. List dnly one cause<br>Immediate Cause (Final disease                                 | a Torso In  |                                      |                        |                                 |                           |                                     |                  | 4                            | Between Onset and<br>Death                       |
|  |                 | or condition resulting in death)   | Due to (or as a co  | onsequence of):                      |                        |                                 |                           |                                     |                  |                              |  |
|  | ine             | Sequentially list conditions,<br>if any, leading to immediate<br>cause. Enter Underlying Cause | Due to (or as a co  | onsequence of):                      |                        |                                 |                           |                                     |                  |                              |  |
| d<br>Sit   | xam             | (Disease or injury that initiated events resulting in death) Last                              | Due to (or as a co  | onsequence of):                      |                        |                                 |                           |                                     |                  |                              |  |
| 68760,<br>certificate be executed<br>nding physician and<br>se as the burial - transit   | edical Examiner | X UNPENDED   | d AMENDED 2   | 3a,27,28                             | 8a-f,p                 | er me,g9                        | 27 5-2                    | 21-12 sm                            |                  |                              |  |
|  |                 | IF FEMALE:<br>23b. Was decedent pregnant in t  |   | tcome of pregnar                     |                        | al death 3                      | Ectopic pr                | egnancy                             |                  | Date of delivery             | ay Year  |
| Box 6876(e death certificate the attending physed for use as the bed   | Physician/M     | past 12 months?  1 Yes 2 No 9 V Ur   | 4 Pregnar   | t at time of death                   | - =                    | er (Specify)                    |                           | ognanoy                             | "                | ioriai D                     | ay rour  |
| he de de de de de de de de de de de de de  | Phy             | Part II. Other significant condi   | Ja Olikilow   |                                      | Iting in the ur        | nderlying cause gi              | ven in Part I.            | 23e. Did                            | tobacco use      | e contribute to t            | he cause of death?                               |
| - 8 .50 g  | d b             |  |   |                                      |                        |                                 |                           | 1 Ye                                | es 2 🔲 N         | No 3 Prob                    | ably 4 🗹 Unknown                                 |
| cords,<br>law requir<br>has been s   | Completed       |  |   |                                      |                        | 41                              |                           | 24a. Was                            | psy              | prior to co                  | opsy findings available<br>ompletion of cause of |
| Vital Recc<br>ysician: The lav<br>his certificate ha<br>director, page 2   | S               |  |   |                                      |                        |                                 |                           | 1 ✔ Yes                             | ormed?<br>2 No   | death?<br>1 ✔ Ye             | s 2 No   |
| of Vital Recing Physician: The After this certificate uneral director, page  | o Be            | 25. Was case referred to medical examiner?  1 ✓ Yes 2 No                                       | [Hospital:  | atient 2 🗸 EF                        | ₹/Outpatient           |                                 |                           | eck only one)<br>ursing Home 5      | Residenc         | e 6 Other:                   |  |
| of \<br>ing Phy<br>After th  | $\vdash$        | 27. Manner of Death  | 28a. Date of (Month, D  | Injury 28<br>ay,Year)                | Bb. Time of In         | jury 28c. Injury                | at Work?                  | 28d. Describe                       |                  |                              | collision  |
| Sion<br>Attendi<br>death.<br>Ector:  | catio           | Natural 5 Pen 2 X Accident Inve  | estigation Id 4-  |                                      | d 12:0                 | U pm.                           | es 2 No                   | with f                              | ixed (           | object                       | al Route Number, City                            |
| Divi   | Certification:  |  | lid not be  | Local St                             |                        | t, factory, office bu           | inding, etc.              | or Town,                            | State) <b>St</b> | erling Famsport              | Rd. @ Bower<br>,MD.                              |
| Division of N To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral.   | Medical C       | 29a. Certifier 1 Certifying F  | Physician: To the best of   | of my knowledge,<br>examination and/ | death occurr           |                                 |                           | and due to the cau                  | ise(s) and r     | manner as state              | d  |
| To viii  | Me              | 29b. Signature and title of certifi  | and manner stater   | ed.                                  |                        | 29c. License                    |                           |                                     |                  | ite signed (Mon              | th, Day, Year)                                   |
|  |                 | Unek   |   |                                      |                        | O.C.N                           | 1.E.                      |                                     | April 2          | 28, 2012                     |  |
| JW-0   |                 | <ol> <li>Name and address of person</li> <li>Ana Rubio MD. As</li> </ol>                       | n who completed cause<br>sist <b>ant Medical</b> Ex               |                                      | -                      | more Street, E                  | Baltimore,                | MD 21223                            |                  |                              |  |
| St<br>Regist   |                 | 31. Date filed (Month, Day Year  | 32. Reg   | strar's Signature                    | 1 6                    | ~ 12/                           |                           |                                     |                  |                              |  |
| - Nogist   |                 |  | , 15 th   |                                      | 2 00 0                 |                                 |                           |                                     |                  |                              |  |

12-03372

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| VICKI | e Kamey   |                  | 1- For State<br>Registrar   | State of Maryla                     |                                | ficate of                |                                       | - Wientan I               | _                        | eg. No. 20                            | 12 11.00                          |
|-------|---|------------------|---|-------------------------------------|--------------------------------|--------------------------|---------------------------------------|---------------------------|--------------------------|---------------------------------------|-----------------------------------|
| Mod   | Physici   | an/              | 1. Decedent's Name (First, M  |                                     |                                |                          |                                       |                           | 2. Date of Deat<br>Month | Day Year                              | 1414 hrs                          |
| wea   | ical Exami  | ner              | Vickie Lee  4a. Facility Name (if not insti   | Ramey                               | ımber)                         | 41                       | o. City, Town, or L                   | ocation of Death          | May 1, 20                | 12<br>4c. County of Dea               |                                   |
|       |   |                  | 13100 Block of Kin  |                                     | •                              |                          | Germantown                            |                           |                          | Montgomery                            | ,                                 |
|       | Funeral   |                  | 5. Social Security Number   | 6. Sex                              | 7. Age (In yrs. last           | birthday)                | If Under 1 Year<br>Months Days        | If Under 24Hrs Hours Min. | _                        | th(MM/DD/YYYY) 9. I                   | Birthplace (State or eign         |
|       | Director  |                  | 217-70-8758   | 1 M 2 X F                           | 56                             | Yrs.                     | Monais Bays                           | Tiours William            | March 4                  | 4, 1956                               | Country)MD                        |
|       | яну   |                  | Usual Residence of Deceder<br>10a. State 10b. Cou   |                                     | 10c. City, To                  | own or Locatio           | n                                     |                           |                          |                                       | 10d. Inside City Limits           |
|       | in:   | _                | MD  | Montgomery                          | Olr                            | ney                      |                                       |                           |                          |                                       | 1 Yes 2 No                        |
|       | Maryland<br>28a-f show<br>d at once   | Director         | 10e. Street and Number  |                                     |                                |                          | 10f. Zip Code                         |                           |                          | 0g. Citizen of What Co                | ountry?                           |
|       | th the 23a or   | Ö                | •   | sborough Dri                        |                                | 140 394                  | 20832                                 |                           |                          | USA                                   | orione to diag. Disale            |
|       | ath wi  | Funeral          | 11. Marital Status 1 Never Married 2  | Married Armed F                     |                                |                          | Decedent of Hisp<br>s, specify Cuban, |                           |                          | White, etc.                           | erican Indian, Black,             |
|       | ifter de<br>il", or<br>ner mu   | by Fu            | 3 Widowed 4 X   | Divorced If Yes, Give Yes or Dates: | 2 X No                         | 1 🗆 🕥                    | res 2 No                              | specify:                  |                          | SpecifyWhit                           | e                                 |
|       | hours a<br>natura<br>Cxami  | ed b             | 15. Decedent's Education (  | Specify only highest grad           |                                |                          | s Usual Occupationst of working life. |                           |                          | 16b. Kind of Busines                  | s/Industry                        |
|       | 36<br>iin 72<br>ii.   | plet             | Elementary/Secondary (0-  | 12) College (1                      | 1-4 or 5+)                     | Acco                     | ountant                               |                           |                          | Law                                   |                                   |
|       | 5-00<br>ed with<br>lygien<br>other  | Completed        | 17. Father's Name (First, Mic   | idle, Last)                         |                                | 11000                    |                                       | 8. Mother's Name          | (First, Middle, N        | Maiden Surname)                       |                                   |
|       | 1218<br>be fillental H<br>urked   | Be               | Al Costantin  |                                     |                                |                          |                                       | Myrna Gi                  |                          |                                       |                                   |
|       | MD 21215-0036<br>d 2 should be filed within 7<br>tth and Mental Hygiene.<br>n 27 is marked other than<br>wmatic event, the Medica   | 10               | 19a. Informant's Name/Relati  |                                     |                                | _                        | Address (Street<br>)ueensbo:          |                           |                          | nber, City or Town, Sta<br>Uney, MD 2 |                                   |
|       |   | 100              | 20a. Method of Disposition  |                                     | 20b. Plac                      | ce of Dispositi          | on (Name of cerr                      | netery,                   | Date                     | 20c. Location - City                  |                                   |
|       | ages lent of l  |                  | 1 Burial 2 X Cremi  | ation 3 Removal fr                  |                                | matory or othe<br>opolit | an Crema                              |                           | ay 3,<br>2012            | Alexandr                              | ia, VA                            |
|       | Baltimore, permit. Pages 1 ar Department of Hee Important: If ite   |                  | 21 Signature of Funeral Ser   |                                     |                                | 22 Na<br>Fra             | me and Address                        |                           |                          | 1 Home Inc                            | ng, MD 20901                      |
|       |   |                  | Aames C   |                                     | roughed the death. Do          | p00                      | Univers                               | ity Blvd                  | . W., S                  | ilver Spri                            | ng, MD 20901 Approximate Interval |
|       | Physician //Medical   |                  | 23a. Port I. Enter the disease failure. List only one ca                                      | use on each line.                   | ed drug(C                      | codeine                  | Diphen                                | hydramin<br>Zolnider      | e,Mirtz                  | apine,<br>cohol intoxic               | Between Onset and                 |
|       | Examiner  |                  | Immediate Cause (Final disc<br>or condition resulting in deat                                 |                                     | consequence of):               | an, Que                  | стартие,                              | ZOIPIUCI                  | ii) dila ai              | 0012012 22-0-22-0                     |                                   |
|       | es from   | ايا              | Sequentially list conditions,   | b.                                  | a consequence of):             |                          |                                       |                           |                          |                                       |                                   |
|       |   | 힐                | if any, leading to immediate<br>cause. Enter Underlying Ca<br>(Disease or injury that initiat | use<br>c.                           |                                |                          |                                       |                           |                          |                                       |                                   |
|       | $\mathcal{B}^{\varepsilon}$   | Exa              | events resulting in death) La   | ast Due to (or as a                 | a consequence of):             |                          |                                       |                           |                          |                                       |                                   |
|       | execut<br>an and<br>al - tra  | Medical Examiner | X UNPENDED  | d AMENDED                           | 23a,27,28                      | a-f,pe                   | r me,g92                              | 27 5-11-                  | 12 sm                    |                                       |                                   |
|       | 760,<br>cate be<br>physici<br>he buri   | /Med             | IF FEMALE:  |                                     | outcome of pregnan             | псу                      |                                       |                           |                          | 23d. Date of delive                   | •                                 |
|       | certification   | ian/             | 23b. Was decedent pregnant<br>past 12 months?   | 1                                   | oirth<br>nant at time of death | _ =                      | Ideath 3 L<br>er (Specify)            | Ectopic pregna            | incy                     | Month                                 | Day Year                          |
|       | Box<br>death<br>the atte  | Physician/N      | 1 Yes 2 No 9  | Unknown 9 Unknown                   | own                            | O Dak                    |                                       |                           |                          |                                       |                                   |
|       | that the  | by PI            | Part II. Other significant co   | nditions contributing to            | o death but not resu           | ilting in the un         | derlying cause gi                     | ven in Part I.            |                          |                                       | to the cause of death?            |
|       | Division of Vital Records, P.O. Box 687, rs or Attending Physician: The law requires that the death certificity as after death. Attenthis certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the  | ted              |   |                                     |                                |                          |                                       | -                         | 24a. Was a               |                                       | autopsy findings available        |
|       | COFC  | Completed        |   |                                     |                                |                          |                                       |                           | autop:<br>perfor         | med? death?                           |                                   |
|       | l Re<br>a: The<br>tificate<br>ox, pag   |                  | 25. Was case referred to me   | dical                               |                                |                          | 26.Place                              | of Death (Check           | 1 Yes :                  | 2 No 1 🗸                              | Yes 2 No                          |
|       | Vita<br>ysicia<br>ysicia<br>ysicia<br>direct  | To Be            | examiner?<br>1 ✓ Yes 2 No   | Henrital:                           | Inpatient 2 ER                 | R/Outpatient             | 3 DOA                                 | Other Nursin              | g Home 5                 | Residence 6 🗸 Ott                     | ner: Scene                        |
|       | n of<br>ing Ph<br>After<br>funeral  |                  | 27. Manner of Death   |                                     | n, Day,Year)                   | Bb. Time of Inj          |                                       | y at Work?                |                          | now injury occurred took medi         | cations                           |
|       | Sior<br>Attend<br>death.<br>ector:<br>by the  | Sati             | 2 Accident  | rivestigation                       | ce of Injury - At home         | d 02:1                   | Ори —                                 |                           |                          |                                       | Rural Route Number, City          |
|       | DIVI  | Certification:   |   | Jould not be                        | Found: Car                     |                          | , ractory, office be                  | anding, etc.              | or Town, S               | tate)13100 B1<br>rmantown,M           | cok of Kinster                    |
|       | Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 butus after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit |                  | 29a. Certifier 1 Certifyin  | a Physician: To the be              | st of my knowledge,            | death occurre            | ed at the time, dat                   | te and place, and         | due to the caus          | e(s) and manner as st                 | ated.                             |
|       | To the<br>within<br>To the  | Medical          | one) 2 Medical  | Examiner: On the basis and manner s | of examination and/ostated.    | or investigatio          |                                       |                           | t the time, date :       |                                       |                                   |
|       | 5-4   | 添                | 29b. Signature and title of ce  | ntitier                             | /11                            | $\mathcal{T}$            | 29c. License<br>O.C.N                 |                           |                          | 29d. Date signed (A May 2, 2012       | rionth, ∪ay,Year}                 |
|       |   |                  | 30. Mame and sidress of pe  | rson who complete cau               | se of death (Item 22           | /-<br>Ba)                | 3.3.1                                 |                           |                          | , 2, 2012                             |                                   |
|       | 9   |                  | Russell Alexander   | MD. Assistant N                     | Medical Examin                 |                          | V. Baltimore                          | Street, Baltim            | ore, MD 212              | 223                                   |                                   |
|       | S   | tate             | 31. Date filed (Month, Day, Y   | 1ar)2012 3 R                        | egistrar's Signature           | hart                     | 1                                     |                           |                          |                                       |                                   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4 13Day 201<sup>Y</sup>2" 12:00 A M Albert Eustace Rolle Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 600 Riverbend Road Fort Washington <u>Prince George's</u> 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Days Hours 0870371935 F18Ttla Director 261-46-4327 76 Usual Residence of Decedent ms 23a or 28a-f sho must be notified at 10a, State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Directo 1 X Yes 2 No Prince George's MD Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 600 Riverbend Road 20744 items ? 12, Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give 1982-1991 Year or Date 1982-1991 3 Widowed 4 Divorced Specify: Black "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than ther traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) General Surgeon Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bessie Green Jerod Rolle, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11860 Northwest 7th Street Plantation, FL 33325Allyson Harrison/Daughter t: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ğ Department of Important: If any injury or 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metropolitan Crematory 4/18/12 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) ure of Funeral Service Licensee Signal 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition End Stage Renal Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Year ed by the a 9 Unknown 9 Unknown P.O. I signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, the Hospital or Attending Physician: The law requires cate has been signated by page 2 should by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼ No 24a. Was an autopsy performed? this certificate 1 Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 \ Residence 6 \ Other (Specify 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Given the last of the lasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Jocelyne 163748 Koucekhou, MD 4/18/12

O A A

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne Kouatchou 201 East University Parkway Baltimore, MD 21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month O 4 Mae Simmons Medical 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** mi If Under If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday **Funeral** Date of \_\_\_ (Month, Day IS 1 🗆 M 2 🗴 Months Davs Year 1916 Mary Land Aug. Director 212-16-7296 28a-f show 10a State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shor Examiner must be notified at 10d. Inside City Limits Director MD Dorchester Church Creek 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1933 Church Creek Road 21622 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Yes 2 X No 1 Never Married 2 Married Completed by Itimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify Specify: "natural", 3 X Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) | Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) owner/operator dress shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louis Riggins Margaret Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Wayne D. Simmons Sr. 1008 Race St., Cambridge, MD son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Old Trinity Churchyard 4/27/12 4 ☐ Donation 5 ☐ Other (Specify) Church Creek, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIOMYO disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami -transit or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician a hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Pregnant at time of death sate has been signed by the spage 2 should be detached 9 Unkplown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes Z No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed this certificate Yes 1 🗌 Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 No ပ HOSPICA 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 2 Accident 5 Pending Μ Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brap 31. Date filed (Month, Day, Year) State

Registrar

|  |                     | Please Type or Pl  |                 |                           |  |                     |                 |                               | _                  | ible.                      |                                     |
|--|---------------------|--|-----------------|---------------------------|--|---------------------|-----------------|-------------------------------|--------------------|----------------------------|-------------------------------------|
|  |                     | For State of N   | /larylan        |                           | irtment of F                           |                     | and M           | ental Hy                      | giene              |                            |                                     |
|  |                     | Registrar  |                 | Cer                       | tificate of L                          | Death               |                 |                               | Reg. No. 2         | 112                        | 498                                 |
| Physicia   | an/                 | 1. Decedent's Name (First, Middle, Last)   |                 |                           |  |                     |                 | 2. Date of De<br>Month        |                    | Voor                       | 3. Time of Death                    |
| Medi   |                     | Adele  | Sklar           |                           |  |                     |                 | April                         | 2 <sup>Day</sup> 2 | 012                        | 9:15 am                             |
| Examir   |                     | 4a. Facility Name (if not institution, give street and number,   |                 |                           | 4b. City, Town, or                     | Location of         | f Death         |                               | 4c. County         | of Death                   |                                     |
|  |                     | Kensington Park Retiremen  | t Comi          | nunity                    | K                                      | <i>(ensin</i>       | igton           |                               |                    | Monte                      | zomery                              |
| Funeral  |                     | T70 10 01T0  | ige (In yrs. la | st birthday)              | If Under 1 Year<br>Months Days         | If Under 2<br>Hours | 24 Hrs.<br>Min. | 8. Date of Birl<br>(Month, Da | :h                 |                            | lace (State or Foreign              |
| Director   | Į.                  | 579-62-9452 1 □ M 2 <b>1</b> □ M 2 <b>1</b> □ M  | 97              | Yrs.                      |  |                     |                 |                               | 12,1915            |                            | )hio                                |
| nd<br>at   | -                   | Usual Residence of Decedent  10a, State  10b, County   | 10c City        | , Town or Loc             | ation                                  |                     |                 | 1,000                         | , , , , , , ,      |                            | Od. Inside City Limits              |
| a-f sl   | 5                   | Maryland Montgomery  | 1               | ,, 10111101 400           |  | (ensin              | aton            |                               |                    | "                          | 1 Yes 2 X No                        |
| r 28g  |                     | 10e. Street and Number   |                 |                           | 10f. Zip Code                          |                     | 9,0071          |                               | 40 000 00          | 1 10 1                     |                                     |
| ith th   | <u>a</u>            |  | #110            |                           | Tot. Zip Gode                          | 00005               |                 | - 1                           | 10g. Citizen of V  |                            | -                                   |
| ath w  | by Funeral Director | 3616 Littledale Road,  11. Marital Status 12. Was Deceden  |                 | 13 14                     | /as Decedent of Hi                     | 20895               |                 | ify Ves or No-                | 144 David          |                            | S.A.                                |
| or ite   | Ž                   | 1 Never Married 2 Married 1 Yes 2  | ?               | If                        | Yes, specify Cuba                      | n, Mexican,         | Puerto Ri       | ican, etc.)                   |                    | e - America<br>k, White, e |                                     |
| s afte   | l b                 | 3 X Widowed 4 ☐ Divorced If Yes, Give Year or Dates.   | 6110            | 1                         | ☐ Yes 2 🗶 No                           | Specify:            |                 |                               | Specify:           | Ca                         | ucasian                             |
| hour<br>natur<br>lical   | Completed           | 15. Decedent's Education   |                 |                           | ent's Usual Occupa                     |                     |                 |                               | 16b. Kind of Bu    |                            |                                     |
| n 72<br>an " <sub>I</sub>  | μğ                  | (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 o                                 | · 5+)           |                           | ind of work done a<br>NOT use retired) | during most o       | of working      | 9                             |                    |                            | ,                                   |
| within giene er th   |                     | 12   | 017             |                           | Homen                                  | naker               |                 |                               | 0                  | wn Ho                      | me                                  |
| filed<br>al Hy<br>d oth  | Be                  | 17. Father's Name (First, Middle, Last)  |                 |                           |  | 18. Mother          | r's Name (      | (First, Middle,               | Maiden Surname     | )                          |                                     |
| d be<br>Venta  | 오                   | Harry Coff   | ey              |                           |  |                     |                 | Sadi                          | e Notes            |                            |                                     |
| and hand is me   |                     | 19a. Informant's Name/Relationship (Type, Print)   |                 | 19b. Mailin               | g Address (Street a                    | and Number          | or Rural I      | Route Numbe                   | , City or Town, Si | tate, Zip Co               | ode)                                |
| od 2 salth<br>n 27<br>er tra   | 1                   | Susan Goldstein - Daughte  | た<br>て          | 9605                      | Culver S                               | Street              | , Ke            | nsingt                        | on, Mary           | land                       | 20895                               |
| of He  |                     | 20a. Method of Disposition   | 20b. P          | lace of Dispos            | ition (Name of<br>atory or other plac  | e)                  | Da              | ate                           | 20c. Location -    | City or Tov                | vn, State                           |
| Page<br>nent<br>nnt: I   |                     | 1 X Burial 2 ☐ Cremation 3 X Removal from Star<br>4 ☐ Donation 5 ☐ Other (Specify)                                 | .0              |                           |  |                     | 4/25            | 12012                         | Falls C            | hurch                      | ı, Virgini                          |
| permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  |                     | 21. Signature of Funeral Service Licensee  |                 | 621 22                    | Name and Addres                        | s of Facility.      | Hino.           | s-Rina.                       | Pdi Funo           | ral t                      | lome, Inc.                          |
| S a la C   |                     | Neva n Fund  | cle             | 118                       | 300 New H                              | lampsh              | ire             | Ave., S.                      | ilver Sp           | ring.                      | MD 20904                            |
|  |                     | 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each li | ed the death    | . Do not ente             | the mode of dying                      | g, such as ca       | ardiac or       | respiratory arr               | est,               |                            | Approximate                         |
| Physician/   |                     | Immediate Cause (Final   |                 | Hoast                     | Egiluno                                |                     |                 |                               |                    |                            | Interval Between<br>Onset and Death |
| Medical  |                     | disease or condition resulting in death)  a. Conge  Due to (or a   | s a consequ     | ence of):                 | Failure                                |                     |                 |                               |                    | _                          |                                     |
| Examiner   |                     | Athen  |                 |                           | leart Dis                              | oako                |                 |                               |                    |                            |                                     |
|  | ner                 | if any, leading to immediate Due to (or a  |                 |                           | Teace vos                              | i ews e             |                 |                               |                    |                            |                                     |
| s be executed /sician and e burial transit   | Examiner            | cause. Enter Underlying Cause (Disease or injury that initiated events  c. Parki                                   | nson'           | 5                         |  |                     |                 |                               |                    |                            |                                     |
| be execut  |                     | resulting in death) Last Due to (or a  |                 |                           |  |                     |                 |                               |                    |                            |                                     |
| s be y<br>ysicia<br>e bu   | lical               | 📞 d Hyper  | tensi           | on                        |  |                     |                 |                               |                    |                            |                                     |
| eath certificate k<br>attending physi<br>d for use as the  | Physician/Med       | IS SENANCE   |                 |                           |  |                     |                 |                               |                    |                            |                                     |
| endir<br>use   | an/I                | IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth   |                 |                           | Ectopic pregnanc                       | V                   |                 |                               | 23d. Dat           | e of deliver               | У                                   |
| death<br>e att   | sici                | 1 Yes 2 No 4 Pregnant  | at time of d    |                           | Other (specify)                        | у                   |                 |                               | Mor                | nth [                      | Day Year                            |
| the o  | hy                  | 9 LI UNKNOWN   |                 |                           |  |                     |                 | 1                             |                    |                            |                                     |
| requires that the deg<br>been signed by the a<br>should be detached  | by                  | Part II. Other significant conditions contributing to death  | but not resu    | ulting in th <b>e u</b> r | derlying cause giv                     | en in Part I.       |                 | 23e. Did to                   | bacco use contri   | bute to the                | e cause of death?                   |
| quires<br>en siç<br>ould b   | ed                  |  |                 |                           |  |                     |                 | 1 🗆 `                         | res 2 💢 No         | 3 Proba                    | ably 4 🗌 Unknown                    |
| w rec  | Completed           |  |                 |                           |  |                     |                 | 24a. Was a                    |                    |                            | sy findings available               |
| The la<br>ate ha   | mo.                 |  |                 |                           |  |                     |                 |                               | rmed? d            | eath?                      | pletion of cause of                 |
| sician: The law r<br>certificate has b<br>lirector, page 2 s   | Be C                | 25. Was case referred to medical   |                 |                           | 26. Pla                                | ace of Death        | (Check o        |                               | 2 <b>X</b> No 1    | Li fes 2                   | : L 140                             |
| ysici;<br>s cer<br>direc   | To B                | examiner?  1  Yes 2 No Hospital:   | tient 2 🗆 I     | ER/Outpatient             | Othe                                   | r: _                | ,               |                               | ence 6 🗆 Othe      | r (Snecify)                |                                     |
| g Ph<br>er thi<br>neral  |                     | 27. Manner of Death 28a. Date of in  | ury             | 28b. Time of              | 28c. Injury                            | at                  |                 |                               | ow injury occurre  |                            |                                     |
| ath.<br>F: Aff   | Certificate:        | 1 X Natural 5 □ Pending (Month, D<br>2 □ Accident □ Investigation  | ay, 16a1)       | injury                    | M 1 🗆                                  | /<br>Yes 2□N        | No              |                               |                    |                            |                                     |
| Atte   | rtif                | 3 Suicide 6 Could not be 4 Homicide determined   | jury - At hor   | me, farm, stre            | et, factory, office                    |                     | 28              |                               | treet and Numbe    | r or Rural F               | Route Number,                       |
| alor<br>s afte   |                     | bullaing, e  | tc. (Specify)   |                           |  |                     |                 | City or Tow                   | n, State)          |                            |                                     |
| To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  within 24 hours after death.  Popipiere of the Funeral Director. After this certificate has been signed by the attending phy.  Popipierely filled in by the funeral director, page 2 should be detached for use as the | Medical             | 29a. Certifier 1 Certifying Physician: To the best of  |                 |                           |  |                     |                 |                               |                    |                            |                                     |
| he H<br>iin 24<br>he Ft<br>pplete  | Mec                 | (Check 2   Medical Examiner: On the basis of only one) 3   Certifying Nurse Practitioner: To                       |                 |                           |  |                     |                 |                               |                    |                            |                                     |
| of the first   |                     | 29b. Signature and title of certifier  |                 |                           | 29c. License                           | number              |                 |                               | 29d. Date signed   |                            |                                     |
|  |                     | > Hayhed &   |                 |                           |  | D536                | 91              |                               | 412                | 1/20                       | 12.                                 |
|  |                     | 30. Name and address of person who completed cause of  |                 |                           |  |                     |                 |                               |                    |                            |                                     |
|  |                     | Ajay Reddy, M.D., 3200 To  | wer 0           | aks Bli                   | d., #110                               | , Roc               | .kvil           | le, Ma                        | ryland 2           | 0852                       |                                     |
| Stat   | te                  | 31. Date filed (Month, Day, Year) APR 2 6 2012   | rar's Signati   | ire                       | . 4                                    |                     |                 |                               |                    |                            |                                     |
| Registra   | ar                  | ATR & U ZUIZ Senera  | A.              | gar                       |  |                     |                 |                               |                    |                            |                                     |

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14985 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:00am Jeanne Elizabeth Skelly 2012 pril Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Renaissance Gardens - Riderwood Silver Spring Prince George's al Security Number If Under Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F (Mogth 72.671927 Months 176-22-1111 Pennsylvania **Director** Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Silver Spring 1 Yes 2 X No Prince George's Maryland | 10e. Street and Number 10f. Zip Code Hygiene. other than "natural", or items 23a or rent, the Medical Examiner must be r 10g, Citizen of What Country? Funeral 20904 U.S.A. 3146 Gracefield Road, 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chief of Blood Bank Holy Cross Hospital traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ည Louis J. Skelly Marion Agnes Joines permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25229 Cascade Road, Cascade, Maryland 21719 Mary Lou Carden Black - Niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 04/28/2012 Silver Spring, Maryland Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral flome, Inc. 21. Signature of Funeral Service Licenses monto 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Poset and Death Month Physician/ Pulmonary Embolism disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 1 Month Bilateral Deep Venous Thrombosis figure tielly ist or ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of Exami 6 Years Atrial Fibrillation Due to (or as a consequence of): resulting in death) Last physician s the burial burial Physician/Medical Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ξ in the past 12 months? Month Day Year Pregnant at time of death ed by the a detached to Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal Insufficiency Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed Congestive Heart Failure 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director. After this certificate it 2 X No 1 Yes 2 No Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland 20904 3160 Gracefield Road, Silver Spring, CRNP, Eileen Gemmell,

State

Registrar

31. Date filed (Month. Day, Year

APR 26 2012

2. Registrar's Signature

Registrar

State

31. Date filed (Month, Day, Year)

APR 26 2012

back

Registrar's Signature

|                |   |                     | _ For  | Pleas  | se Type or P<br>State of  |                                 |  |   | . Ensure A<br>Health and I                 | -                                      |                           | •                                   |  |
|----------------|---|---------------------|--|--|---|---------------------------------|--|---|--|--|---------------------------|-------------------------------------|--|
|                |   |                     | 1 - State<br>Registrar   |  |   |                                 | Cei                                    | rtificate of  | Death                                      |  | Reg. No.                  | 201                                 | 2   498  |
| Ī              | Physici<br>/Medi  |                     | 1. Decedent's Nan  | ne (First, Middle,                                   |   | A. Sava                         | age                                    |   |  | 2. Date of De Month 04                 | eath<br>Day<br>I 7        | 7 Žea 2012                          | 3. Time of Death 2:08 PM                           |
| and the second | Examir  | ner                 | 217 Shenano  | doah Ave.  | give street and num.  |                                 |  |   | or Location of Death<br>Mt Lake Par        | k                                      |                           |                                     | arrett   |
|                | Funeral<br>Director   |                     | 5. Social Security I 217-28- Usual Residence of  | 9551   | 6. Sex<br>1 ☑ M 2 □ F   | 7. Age (In yrs.                 |  | If Under 1 Year<br>Months Days                        | If Under 24 Hrs.<br>Hours Min.             | 8. Date of Bi<br>(Month, D<br>08/0     | rth<br>7/1932             | 9. Birt                             | hplace (State or Foreign<br>untry)<br>MD           |
|                | show  |                     | 10a. State   | 10b. County  |   | 10c. Cit                        | ty, Town or Lo                         | cation  |  |  |                           |                                     | 10d. Inside City Limits                            |
|                | the Ma<br>28a-f s   | ecto                | MD<br>10e. Street and Nu   |  | Garrett   |                                 |  | 10f. Zip Code   | Mt Lake Park                               | ζ                                      | 10g Citi                  | zen of What Co                      | 1 X Yes 2 No                                       |
|                | 3a or   | Ö                   | 217 Shenano  |  |   |                                 |  | Toi. Zipcode  | 21550                                      |  | rog. Citi                 | US                                  | -  |
| 980            | be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Expriring must be notified at                                 | by Funeral Director | 11. Marital Status   | ried 2 <mark>7</mark> Marrie                         | 12. Was Deced<br>Armed Ford<br>1 Z Yes 2<br>If Yes, Give<br>Year or Dat | es?<br>!                        |  | Vas Decedent of I<br>fYes, specify Cub<br>I □Yes 2 No | Hispanic Origin? (S<br>an, Mexican, Puert  | pecify Yes or No<br>o Rican, etc.)     |                           | 14. Race - Ame<br>Black, White      | rican Indian,                                      |
| 2-0            | 72 hou<br>natura  | eted                | (Spe   | 15. Decedent's                                       | s Education<br>t grade completed)                                       |                                 |  | dent's Usual Occu                                     | pation<br>during most of work              | kina                                   | 16b. Kir                  | nd of Business/                     |  |
| 21215-0036     | within ene.   | Completed           | Elementary/Sec   | ondary (0-12)  | College (1-4  | for 5+)                         | life. I                                | OO NOT use retire                                     | ales                                       | g                                      |                           | Min                                 | ino  |
|                | filed withii<br>I Hygiene.<br>other than<br>rent, the M   | Be Co               | 17. Father's Name  |  | ast)  |                                 | I.                                     |   | 18. Mother's Nam                           | ne (First, Middle                      | , Maiden                  |                                     |  |
| /lan           | 2 should be filed and Mental Hygi is marked other aumatic event, It   | TO B                |  |  | Gilbert Sav   | age                             |  |   |  | M                                      | ildred 1                  | Amos                                |  |
| Maryland       | S 8 8 5   |                     | 19a. Informant's N   |  | ip (Type. Print)  |                                 | 1                                      | -   | and Number or Ru                           |  |                           | r Town, State, 2                    | Zip Code)  |
| re, l          | Health<br>tem 27 other tra  |                     | Loraine Sava<br>20a. Method of Dis   |  |   | 20b. F                          |  | sition (Name of natory or other pla                   | ve., Mt Lake                               | Date Date                              | ,                         | cation - City or                    | Town, State  |
| OE.            | Pages nent of hant: If ite  |                     |  | Cremation 5 ☐ Other (Sp                              | 3 ☐ Removal from St   | ate                             |  | natory`or other pla<br>al Gardens Crei                | i  | 8/2012                                 |                           | Kingwoo                             | od, WV   |
| Baltimore,     | permit. Pages 1 an<br>De, artment of Heal<br>Imp ortant: If item 2<br>any injury or other   |                     | 21. Signature of F   | uneral Service L                                     | icensee   | ,                               |  | . Name and Addre                                      | •  | e, P.A. 21 No                          | rth Seco                  |                                     | akland, MD 21550                                   |
|                |   |                     | shock, or he   | art failure. List o                                  | complications that can  | used the deat<br>ch line.       |  |   |  |  |                           |                                     | Approximate<br>Interval Between<br>Onset and Death |
| 14             | Physician<br>/Medical   |                     | Immediate Cause<br>disease or conditi<br>resulting in death)                           | ion  | _a  | yphi                            | 15em                                   | ~   |  |  |                           |                                     | years  |
| تبهي           | Examiner  |                     |  |  | `   | r as a conse                    | uence of):                             |   |  |  |                           |                                     | 0  |
| 8=             | ted<br>nsit   | Examiner            | Sequentially list or<br>if any, leading to in<br>cause. Liner Unio<br>Cause (Disease o | onditions,<br>mmediate<br>enging<br>r injury         | Due to (o   | r as a conseq                   | uence of):                             |   |  |  |                           |                                     |  |
| 68760,         | icate be executed<br>physician and<br>the burial-transit  | 1 – 1               | that initiated event<br>resulting in death)  | (S   | c   | r as a conseq                   | uence of):                             |   |  |  |                           |                                     | · · · · · · · · · · · · · · · · · · ·              |
| 89             | ortificating physics as the   | Medi                | IF FEMALE:   |  |   |                                 |  |   |  |  |                           |                                     |  |
| .O. Box        | Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit | Physician/Medica    | 23b. Was deceder in the past 12 1 Yes 2 9 Unknown                                      | 2 months?<br>□No                                     |   | nth 2 ☐ Feta<br>antat time of c | ıl death 3 [                           | Ectopic pregnand Other (specify)                      | cy   |  | 2                         | 23d. Date of del<br>Month           | ivery<br>Day Year                                  |
| rds, P.        | w requires that<br>been signed to<br>should be deta   | 2                   | Part II. Other sign  | ificant condition                                    | ns contributing to dea  | th but not res                  | ulting in the ur                       | nderlying cause giv                                   | ven in Part I.                             |  | /                         |                                     | the cause of death?                                |
| al Records,    | : The law re<br>cate has be<br>, page 2 sho   | Completed           |  | (0)  |   |                                 |  |   |  | 24a. Was<br>auto<br>perfo<br>1 ∐Yes    |                           | prior to death?                     | topsy findings available completion of cause of    |
| Vital          | ding Physician; Th.<br>h.<br>After this certificate<br>funeral director, pag  | Be                  | 25. Was case refe<br>examiner?<br>1 ☐ Yes 2  | rred to medical                                      | Hospital:   |                                 | JED (0                                 | Ott   | 26. Place of Dea                           | - /                                    |                           |                                     |  |
| ō              | ding Phys<br>n.<br>After this<br>funeral dii  | n: To               | 27. Manner of De   | th   | 28a. Date of  |                                 | ER/Outpatier<br>28b. Time of<br>Injury | I 3LI DOA   | 4 LI Nursing H                             | ome 5 Res<br>28d. Describe             |                           | 6                                   | cify)  |
| Division       | l or Attending<br>after death.<br>Director: After<br>in by the funer  | Certification:      | Accident 3 ☐ Suicide 4 ☐ Homicide  | 5 ☐ Pending<br>investiga<br>6 ☐ Could no<br>determin | ot be 28e. Place o  |                                 | ome, farm, str                         |   | lYes 2 □No                                 | 28f. Location (                        | (Street and<br>wn, State) | d Number or Ru<br>)                 | ıral Route Number,                                 |
| _              | Hospital<br>24 hours<br>Funeral<br>etely fillec   | Medical Ce          | 29a. Certifier<br>(Check only<br>one)  | 1 Certifying<br>Medical E                            | Physician: To the becaminer: On the base and manner                     | sis of examina                  | owledge, deati<br>ation and/or in      | n occurred at the t<br>vestigation, in my             | ime, date and place<br>opinion, death occu | e, and due to the<br>arred at the time | e cause(s)<br>, date and  | ) and manner as<br>I place, and due | s stated. to the cause(s)                          |
|                | To the within To the Comple   | ž<br>/L             | 29b. Signature and   | d title of certifier                                 | etas  | Kim                             | M                                      | 29c. Licens   | 450  |  | 4.                        | te signed (Monti                    | 2012   |
|                | 3   | VA                  | 30. Name and add   | lress of person w                                    | ho completed cause  | of death (Iten                  | n 23a) (Type,                          | Print)  | highway                                    | m= D                                   | 0,                        | 1 1/1                               | 1650   |
|                | Sta   | te                  | 31. Date filed Mor   |  |   | gistrar's Signa                 | 1019<br>ture                           | gainer  | morning                                    | vays                                   | and                       | ) NOS -                             | 4))  |
| DL             | Registr   |                     | A  | PR 182   | U12 Cela  | m p                             | . 40                                   | je.   |  |  |                           |                                     |  |

| Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Months   Days  | 2. Date of Dea<br>Month<br>May 2, 20<br>ation of Death   | Day Year                                      | 2 49 {<br>3. Time of Death<br>2229 hrs        |
|---|--|---|---|
| Physician/ 1. Decedent's Name (First, Middle, Last)  Medical Examiner  John Wayne Strayer  4a. Facility Name (if not institution, give street and number)  Carroll Hospital Center  Funeral  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  Months Days  Months Days  | 2. Date of Der Month May 2, 20 ation of Death  Vestminster f Under 24Hrs. 8. Date of Bi Hours Min. | ath<br>Day Year<br>012<br>4c. County of Death | 2229 hrs                                      |
| John Wayne Strayer   4a. Facility Name (if not institution, give street and number)   4b. City, Town, or Loca   Carroll Hospital Center   Reistertown   Wayne   Funeral   5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If Months   Days   Months   Days   1. Age   Months   Month  | May 2, 20 ation of Death  Vestminster f Under 24Hrs. 8. Date of Bi Hours I Min.                    | 4c. County of Death                           | 2229 hrs                                      |
| 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Local Carroll Hospital Center  Carroll Hospital Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  If Under 1 Year In Months Days In Months Da  | ation of Death  Vestminster f Under 24Hrs. Hours   Min.  | 4c. County of Death                           |   |
| Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If  | f Under 24Hrs. 8. Date of Bi<br>Hours Min.   | Carroll                                       | 1   |
| Months Days   | Hours Min.   |   |   |
|   | 02/02/   | rth (MM/DD/YYYY) 9. Bir<br>Foreig             | n   |
| 220-82-910/ 16 M 2 F 51 Yrs.  |  | /1961 <sup>co</sup>                           | untry) PA                                     |
| Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location   |  |   | 10d. Inside City Limits                       |
| Reisterstown  |  |   | 1 Yes 2 X No                                  |
| The state of the s  |  | 10g. Citizen of What Cou                      | ntry?   |
| MD Carroll Reisterstown    No.   Carroll   Reisterstown   Carroll   Reisterstown  |  | USA   | •   |
| 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispani  | ic Origin? ( Specify Yes or No   |   | can Indian, Black,                            |
| 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 1 Never Married 1 Yes 2 No 1 No  | exican, Puerto Rican, etc.)  | White, etc.                                   |   |
| 3 Widowed 4 Divorced If Yes, Give Year or Dates:  |  |   | ite   |
| 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (during most of working life. DO   |  | 16b. Kind of Business/I                       | ndustry                                       |
| Elementary/Secondary (0-12) College (1-4 or 5+)  Sales  |  | Donggo So                                     | rvices, Inc                                   |
| Tor Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (during most of working life. DO  17. Father's Name (First, Middle, Last)  18.M   | Nother's Name (First, Middle,  |   | IVICES, IIIC                                  |
| - 4 - 3 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1   | Cally Christ   | ŕ   |   |
| Name/Relationship (Type, Print )  19b. Mailing Address (Street and  |  | mber, City or Town, State                     | , Zip Code)                                   |
| Susan Strayer/Wife 3415 Pleasant P.   | lains Drive,   | Reisterstow                                   | n, MD21136                                    |
| 20a. Method of Disposition  20b. Place of Disposition (Name of cemeter crematory or other place)  | ery, Date  | 20c. Location - City or                       | Town, State                                   |
| 1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Carroll Cremation   | 05/07/2012   | Hampstead,                                    | MD  |
| 21. Signature of Funeral Service Licensee 22. Name and Address of F   | <sup>Facili</sup> <b>P</b> ritts Fune  | ral Home an                                   | d Chapel, PA                                  |
| 412 Washingto   | on Road, West  | <u>minster, M</u> D                           | 21157   |
| Physician  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such failure. List only one cause on each line.  | n as cardiac or respiratory arr  | est, snock, or neart                          | Approximate Interval<br>Between Onset and     |
| Immediate Cause (Final disease or condition resulting in death)  a Aspirin-Induced Asthma  Due to (or as a consequence of):   | _  |   | Death   |
| Sequentially list conditions.   |  |   |   |
|   | -  |   |   |
| (Disease or injury that initiated Due to (or as a consequence of):  |  |   |   |
| The part of the pa  |  |   |   |
| \$\frac{1}{8} \frac{1}{8} \frac{1}{12} \frac{1}{12} \text{UNPENDED} \\ \$\frac{1}{8} \frac{1}{12} \text{UNPENDED} \\ \$\frac{1}{8} \frac{1}{12} \text{UNPENDED} \\ \$\frac{1}{8} \frac{1}{12} \text{UNPENDED} \\ \$\frac{1}{8} \frac{1}{12} \text{UNPENDED} \\ \$\frac{1}{8} \frac{1}{12} \text{UNPENDED} \\ \$\frac{1}{8} \frac{1}{12} \text{UNPENDED} \\ \$\frac{1}{8} \frac{1}{12} \text{UNPENDED} \\ \$\frac{1}{8} \frac{1}{12} \text{UNPENDED} \\ \$\frac{1}{8} \frac{1}{12} \text{UNPENDED} \\ \$\frac{1}{12} \text{UNPENDED} \\ \$ | 5-29-12 sm<br>a,27,28a,b,d-  | 6   | 20 6 0 10                                     |
| #4b,per me,g927 5-30-12 sm 23a  #5 per me,g927 5-30-12 sm 23a  #5 per me,g927 5-30-12 sm 23a  #6 per me,g927 5-30-12 sm 23a   | a,27,20a,D,Q-  | 23d. Date of delivery                         | 28 6-8-12v                                    |
| 2 Sab. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ec  | ctopic pregnancy   | Month D                                       | ау Үеаг                                       |
| X of the state of   |  |   |   |
| O the significant conditions contributing to death but not resulting in the underlying cause given  | in Part I. 23e. Dio to   | bacco use contribute to                       | he cause of death?                            |
| O C specific proof of the proof  | 1  | s 2 🗹 No 3 🗌 Prob                             | ably 4 Unknown                                |
| The law requires figure has been signate has been signate has been signated by page 2 should be Completed   | 24a. Was<br>autop  |   | opsy findings available ompletion of cause of |
| Recording the law page 2 s Comp   Somp   |  | rmed? death?                                  |   |
| Property of the second of the   | Peath (Check only one)   | 2 10 10                                       | 2 10  |
| The second seco   | Nursing Home 5   | Residence 6 Other                             |   |
| 28a. Date of Injury 28b. Time of Injury 28c. Injury at V  |  | how injury occurred                           | and and a law                                 |
| The strong of th  | 2 X No Subject   | ingested A                                    | epitin by                                     |
| 28e. Place of Injury - At home, farm, street, factory, office building (Specify)  Residence   | ng, etc. 28f. Location (5<br>or Town, 5  | Street and Number or Rustate) 3415 Plca       | al Route Number, City                         |
| determined (Specify)  Residence  29a Certifier,   29a Certifier,  | Dr. Re   | <del>isterstow</del> n,                       | ₩.  |
| Pending Investigation 3 Suicide 6 Could not be determined (Specify)  29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and manner stated.  29b. Heading Investigation 3 Suicide 6 Could not be determined (Specify)  Residence  29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and manner stated.  |  |   |   |
| and manner stated.  29b. His nature and the of certifier  29c. License nun  |  | 29d. Date signed (Mor.                        |   |
| 0.C.M.E.  |  | May 3, 2012                                   | ,,  |
| 30. Name and address of person who completed cause of death (Item 23a)  |  |   | <del>.</del>                                  |
| Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Stree  | et, Baltimore, MD 2122   | 23  |   |
| State 31. Date filed (Month, Day, Year) 32. Registrar's Signature   |  |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month. hompson April 0627AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Easton Talbot Hospital at Memorial ston 5. Social Security Number 8. Date of Birth (Month, Day, Ye July 28 **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 M 2 D Days Mary land **Director** ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Easton 1 Yes 2 No Talbot 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2160 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. Be Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sampson dward THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number MD.21613 Deanna ambrid Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Date Department of H Important; If ite any injury or ot Page 1 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Cambridg 12012 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Home, P.A. Str Cambridg Henry F 510 wa Funeral / 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Myocar Immediate Cause (Final Onset and Death Physician/ d disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No page 2 should be detached for Month Day 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 ☐ Unknown 1 Yes 2 No 24a. Was an Were autopsy findings available prior to completion of cause of autonsy death? 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No Certificate: To 1 Yes 1 Inpatient 2 Z ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death Natural 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 1

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of 29d. Date signed (Month, Day, Year) 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 321 ampoi 31. Date filed (Month, Day, State Registrar

Thom PSon

Deborah

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A P 1 Year Physician/ Thompson 1625 PM Thomasine 20 2012 Medical Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Howar. General Howard Hospita columbia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 372-56-9546 **Director** 93 1 🗆 M 2 🖾 F Jan. 4, 1919 Washington, DC 28a-f show ms 23a or 28a-f shormust be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No P.G. Laure1 MD 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral 20707 USA 404 8th Street items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, an "natural", or ite Medical Examiner Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. White by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Religious Elementary/Secondary (0-12) the Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked ot P permit. Page 1 and 2 should be f Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev Catherine E. Doherty Walter E. Thompson 19a. Informant's Name/Relat 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sr. Karen Lester, SAC 404 8th Street, Laurel, MD 20707 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of  $\begin{array}{c} \mathtt{Apri}_{10}^{\mathtt{Date}} 26 \\ 2012 \end{array}$ 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St. Cemetery, crematory or other place St. Mary of the Mills Cemetery Laurel, 4 ☐ Donation 5 ☐ Other (Specify) Francis J. Collins Funeral 500 University Blvd., W., 21. Signature of Funeral Service Licensee Home Inc. Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ PRIS disease or condition Medical resulting in death) Examiner colitis 4 days CLEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Exami The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) resulting in death) Last physician Medical Division of Vital Records, P.O. Box 68760 the attending phase as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown ned by the at detached f 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Jas autopsy performed? Yes 2 No death? After this certificate 2 🗌 No the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No မ 1 Nation 2 ER/Outpatient 3 DOA nours after death.

neral Director: After this of filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending 1 Yes 2 🗌 No 2 Accider
3 Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours Funeral Medical ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 h (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a

Registrar DHMH 17 Rev 06-2011

State

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Tanua Enlasinghe, 5755, Cedar Lane, Columbia, MD, 21044

M.D.

5755,

Registrar's Signature

Kulasinghe

Year

R 2

Tanua 31. Date filed (Month

D71094

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrameno#17perrFH,5/3/12;BMW,MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April Day 2012 Physician/ 19 4:30 PM Rosemary Thompson-Lewis Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's <u>4113 Russell</u> Avenue Mount Rainier 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** 1 □ M 2 🕱 F Months Davs Hours Min (Month, Day, Year, Director 58 579-74-1031 1953 Washington D.C Nov Usual Residence of Decedent 10b. County ural", or items 23a or 28a-f sho Examiner must be notified at 28a-f shor 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Prince George's Mount Rainier Marvland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20712 United States 4113 Russell Avenue Unit A2 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: African American permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exanonce. If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) World Bank 4 <u>Program Assistant</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward 2 Mamie Leach Eugene Thompson 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4113 Russell Avenue, Un Mount Rainier, Maryland Unit A2 and 20712 <u>John W. Lewis, III/Husband</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery: 04/27/2012 Brentwood, Maryland 22 Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, North West Washington, District of Columbia 20012 . Sign ature of Funeral Service/Licensee 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final - Physician/ Metastatic Breast Cancer to Liver and Bones 8 Months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Liver Failure 3 Months Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examin attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Locally Advanced Left Breast Cancer 21 Months Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Day Year Month Pregnant at time of death 5 Other (specify) the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 🔀 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending 1 X Natural Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3

Registrar DHMH 17 Rev 7/2009

State

29b.

30. Name and address of person who completed cause of death (Item 23a) (Type

, MBA

32. Registrar's Signature

John E. McKnight, M.D

Year)

Print)

License numbe

106 Irving Street, Washington, Distric

MD15185

29d. Date signed (Month, Day, Yestr)

North West,

2012

2200N

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 22 **Physician** Month Helen Cason Taylor 2012 5:40 Apri /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Bethesda Carriage Hill Nursing Home If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 💢 F 83 261-38-1733 Florida Director June 16,1928 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 Yes 2 No Director Bethesda Maryland Montaomeru 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20814 U.S.A. 5417 Lambeth Road Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite 1 ☐ Yes 2 **X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify. Caucasian 3 ☐ Widowed 4 👿 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Paralegal Marriott Corporation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel Clarke Hagler Unascertainable 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau once. Linda Taylor Diamond - Daughter 5417 Lambeth Road. Bethesda. Maryland 20814 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) Ft. Lincoln Crematory 04/27/2012 | Brentwood, Maryland 21. Sunatur of Funcial Service Lic nsee 22. Name and Address of Facility Simple Tribute Funeral & Cremation M00709 <u>Center,1040 Rockville Pike,Rockville,MD 20852</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear tabure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Sepsis /Medical Due to (or as a consequence of): Examiner Dysphagia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physiclan: The law requires that the death certificate be executed Dementia and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death 1 □ Yes 2 🗶 No the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 21 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 💹 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

32. Registrar's Signature

Susan J. Miller,

D35579

8218 Wisconsin Avenue, Bethesda, Maryland 20814

201

1 - For State Registrar

Physician/

Medical

**Examiner** 

**Funeral** 

**Director** 

1. Decedent's Name (First, Middle, Last)

236-44-9473

Usual Residence of Decedent

4a. Facility Name (if not institution, give street and number)

Shady Grove Adventist Hospital

1 M 2 D F

| and<br>sho  | اق                | 10a. State  | 10b. County                               |   | 10c. City, Town                     | or Location  |                       |                                      |                                | 10d. Inside City Limits                         |
|---|-------------------|---|---|---|-------------------------------------|--|-----------------------|--------------------------------------|--------------------------------|---|
| faryl<br>3a-f<br>tifiec   | <del> </del>      | <br> Marvland   | Mont                                      | gomery  |                                     | Coit   | hersburg              |                                      |                                | 1 🗌 Yes 2 🗐 No                                  |
| the N<br>or 28  | اَۃً              | 10e. Street and No  |   | gomery  |                                     | 10f. Zip Code  | Hersburg              | 11                                   | 0g. Citizen of What Co         | ountry?   |
| 21215-0036 within 72 hours after death with the Maryland gleine. er than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at             | Funeral Director  |   | 9024 Fdga                                 | wood Drive  |                                     |  | 20877                 |                                      |                                | States  |
| eath<br>ems   | Ë                 | 11. Marital Status  | JOZ / Buge                                | 12. Was Decedent E                                |                                     | 13. Was Decedent of H                                  |                       | pecify Yes or No-                    | 14. Race - Ame                 |   |
| 6 ter d   | by                | 1 🗆 Never Ma  | rried 2 Married                           | Armed Forces? 1 ■ Yes 2 □                         | No 1952-                            |  |                       | o Rican, etc.)                       | Black, Whit                    |   |
| 21215-0036 within 72 hours after giene. er than "natural", o  | ed                | 3 🗷 Widowed   | 4 Divorced                                | If Yes, Give<br>Year or Dates.                    | 1954                                | 1 Yes 2 No   | Specify:              |                                      | Specify: Wh                    | ite   |
| 2 hou   | Completed         | (St   | 15. Decedent's E<br>ecify only highest gr |   | 16a.                                | Decedent's Usual Occup                                 | nation                | rkina                                | 16b. Kind of Business          | Industry  |
| hin 7<br>Than<br>than   | l e               | Elementary/Se   |   | College (1-4 or 5                                 | +)                                  | (Give kind of work done<br>life. DO NOT use retired)   |                       | 9                                    |                                |   |
|   | Be                | 17 Eathor's Name  | (First, Middle, Last)                     | 8   |                                     | Educato  |                       |                                      |                                | Schools   |
| = = = = =   | 10                | 17. Fauler 5 Name   |   | T-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1           | C                                   |  | 18. Mother's Na       | me (First, Middle, M                 |                                |   |
| age 1 and 2 should be<br>nnt of Health and Ment<br>t: If item 27 is markee<br>y or other traumatic e  |                   | 19a Informant's N   | JOHN G.                                   | Timberlak   | 19b. Mailing Address (Street and Nu |  |                       | Marie                                |                                |   |
| 2 shouth and the and trau   | 1                 | 1   |   | eed, Daugh  | - 1                                 | Mailing Address (Street<br>024 Edgewood                |                       |                                      |                                | •   |
| and Hear term   |                   | 20a. Method of Di   |   | baugh   | <del></del>                         | Disposition (Name of                                   | i DIIVE,              |                                      | 20c. Location - City or        |   |
| permit. Page 1 and Department of Heal Important: If item any injury or other and once.  |                   |   | Cremation 3                               | Removal from State                                | cemeter                             | , crematory or other place                             |                       |                                      | •                              |   |
| nit. Partme   |                   |   | unera Service Licen                       | **  | Grace                               | Episcopal  |                       |                                      |                                | West Virgi                                      |
| permit. Page 1<br>Department of<br>Important: If i<br>any injury or<br>once,  |                   | <b>)</b>  | Vanil 6.                                  | faulty/k n  | 101393                              | Moleswort<br>26401 Ric                                 | h-Willia<br>lge Road, | ms, P.A.,<br>Damascus                | , Funeral<br>s, Marylan        | Home<br>d 20872                                 |
|   |                   | 23a. Part 1. Enter  | the disease, or com                       | pplications that caused<br>one cause on each line | the death. Do no                    | ot enter the mode of dyir                              | ng, such as cardiad   | or respiratory arres                 | st,                            | Approximate<br>Interval Between                 |
| Physician   | 4                 | Immediate Cause<br>disease or condit  | (Final                                    |   |                                     | cell carcino   | ma sk                 | in                                   | - 3                            | Onset and Death                                 |
| Medica  | _                 | resulting in death  |   | a. Due tollor as a                                | a consequence o                     | f):  | 711- 91-              | -101                                 |                                | moning  |
| Examine   |                   | Sequentially list of  | onditions                                 | renal   | insuffic                            | iency  |                       |                                      |                                | unknown   |
| _ +   | Examiner          | cause. Enter Und  | mmediate<br>erlying                       | 1   | a Consequence o                     |  |                       |                                      |                                |   |
| outed<br>nd<br>ransi  | Хал               | Cause (Disease of<br>that initiated ever  | r iinjury<br>its                          |   | Kalemia                             |  |                       |                                      |                                | unknown   |
| e exercian a  |                   | resulting in death  | Last                                      |   | a consequence o                     | ŋ:   |                       |                                      |                                | 1   |
| ate be<br>hysic   | di                |   |   | d. <u>Sepsi</u>                                   | <u> </u>                            |  |                       |                                      |                                | hours   |
| The law requires that the death certificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial-transit | Physician/Medical | IF FEMALE:<br>23b. Was deceder  | t prognant                                | 23c. If yes, outcome                              | of pregnancy                        |  |                       |                                      | 23d. Date of de                | B   |
| death certificate be attending physical for use as the b  | icial             | in the past 12 months?  1 Live Birth 2 Fetal death 3 Ectopic pregnancy  1 Yes 2 No  4 Pregnant at time of death 5 Other (specify) |   |   |                                     |  |                       |                                      |                                | Day Year  |
| that the dended by the detached   | hys               | 9 Unknow  |   | 9 Unknown   |                                     |  |                       |                                      |                                |   |
| that<br>ned k   | by P              | Part II. Other sign   | ificant conditions                        | contributing to death b                           | ut not resulting ir                 | the underlying cause gi                                | ven in Part I.        | 23e. Did tob                         | acco use contribute to         | the cause of death?                             |
| quires<br>en sig<br>uld b   | ed                |   |   |   |                                     |  |                       | 1 ☐ Ye                               | s 2 🗆 No 3 🗆 F                 | robably 4 🗷 Unknow                              |
| The law requires ate has been sig   | Completed         |   |   |   |                                     |  |                       | 24a. Was an                          |                                | topsy findings available completion of cause of |
| The la  | l e               |   |   |   |                                     |  |                       | autopsy<br>perform<br>1 ☐ Yes 2      | ned? death?                    | s 2 No  |
| sician: The<br>certificate<br>rector, pag   | Be                | 25. Was case refe examiner?   | red to medical                            |   |                                     | 26. P  | lace of Death (Che    |                                      | , <b>j</b>                     |   |
| nysic<br>nis ce<br>direc  | 2                 | 1 Yes 2   | <b>™</b> No                               | Hospital:<br>1                                    | ent 2 🔀 ER/Out                      | patient 3 DOA Oth                                      | er:<br>4  Nursing H   | Home 5 🗆 Resider                     | nce 6  Other (Spec             | cify)   |
| ng Ph<br>fter th  |                   | 27. Manner of Dea   | th 5 Pending                              | 28a. Date of injui<br>(Month, Day                 | ry 28b. Ti                          | me of 28c. Injur                                       | y at                  | 28d. Describe hov                    |                                |   |
| eath.<br>or: A  | Ę                 | 2 Accident  | Investigatio                              |   |                                     | M 1  | Yes 2 ☐ No            |                                      |                                |   |
| al or Attending Physician: s after death. I Director: After this certific   | Certificate:      | 4 Homicide  |   |   | iry - At home, far<br>:. (Specify)  | m, street, factory, office                             |                       | 28f. Location (Str.<br>City or Town, | eet and Number or Ru<br>State) | ral Route Number,                               |
| To the Hospital or Attending Physician: Within 24 hours after death.  To the Funeral Director, After this certifical completed filed in by the funeral director, I  | Medical           | (Check  | 2 Medical Exam                            | niner: On the basis of ex                         | xamination and/or                   | eath occured at the time<br>investigation, in my opini | on, death occurred    | at the time, date and                | place, and due to the          | cause(s) and manner stat                        |
| o the<br>ithin<br>o the   | Σ                 | only one)<br>29b. Signature and   |   | se Practioner: To the                             | best of my knowle                   | edge, death occurred at the                            |                       |                                      |                                |   |
| F 3 F 8   |                   | De  | lierah )                                  | Sherrie   | emo                                 |  |                       | 25                                   | April 21, 3                    | 017   |
| BX  | 1                 | 30. Name and add  | lress of person who                       | completed cause of de                             |                                     | ype, Print)<br>Lical Cent                              | er Drive,             | poderil                              | April 21, 2<br>le, Manyle      | nd 20850  |
|   | ate               | 31. Date filed (Mo)   |   |   | r's Signature                       |  | V /                   |                                      |                                |   |
| Regist  |                   | 1   | APR 24                                    | 2012 Jens   | un A.                               | barred   |                       |                                      |                                |   |

John G. Timberlake, Jr.

7. Age (In yrs. last birthday)

81

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Months

Yrs.

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Rockville

Min

Hours

2. Date of Death

8. Date of Birth (Month, Day, Year) Sept. 4, 1930

21 pay

2012<sup>ear</sup>

Montgomery

4c. County of Death

0545 AM

9. Birthplace (State or Foreign Country) West Virginia

April

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 per MD FCHD TM 4/24/12 State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2012 April 13, **Physician** Patricia Tilmont 6:25 A. M Α. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Kline Hospice House Mt. Airy If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months 1 M 2 F 74 185-30-6893 12, 1937 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at Maryland Frederick New Market XXYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21774 210 Quaker Way Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 🛣 No Specify: Specify \$ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumatic event, the Medicone. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Josephine Anuskiewicz Louis Lishewski ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 210 Quaker Way, New Market, Maryland Edward M. Tilmont - son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 4-19-2012 Lycoming Co., Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sign, ure of Funeral Service Licensee Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CLL 12 years **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause the light of that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar Due to (or as a consequence of): Physician/Medical the as IF FEMALE nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown signed by be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed nyhadenojat 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2□ No 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospice Hospital: Other: 4 Nursing Home 5 Acsidence 6 MOther (Specify) House 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဥ funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital e Hospital or Attending Pi 24 hours after death. e Funeral Director; After t To the Hospital within 24 hours at To the Funeral C completely filled in

requires that the death certificate be executed

physician

attending

the

ģ

peen

nas

certificate

this

After 1

Physician:

Box 68760.

P.0.

Records,

death with the Maryland

filed within 72 hours after

Maryland 21215-0036

Baltimore,

State Registrar

Coldsiein 501 W 00 6. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certification

32. Registrar's Signature

29c. License number

D0067691

Frederich MD

29d. Date signed (Month, Day, Year)

04-13-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Death Physician/ Month Day 20 4 Barbara J. Tackett 2:15 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace, MD Harford Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Days Hours Country) 41/26/11/940 Director 216-38-4614 71 PA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Cecil Port Deposit 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 271 Peppermint Drive 21904 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marvin Lucas Mae Steenland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earney Tackett - husband Peppermint Drive, Port Deposit, MD 21904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔼 Burial 2 🗌 Cremation 3 🗐 Removal from State Brookview Cemetery 4/25/2012 4 ☐ Donation 5 ☐ Other (Specify) Rising Sun, MD Signature of uneral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between RESP, RATORY Immediate Cause (Final Onset and Death PISTRESS Physician Medical resulting in death) Due to (or as a consequence of) Examiner , PATION NEIMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? signed by the atte Yes 2 No 9. Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by TOBACCO Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: 유 1 / Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Division of Certificate: 27. Manner of Death Hospital or Attending Pl24 hours after death.Funeral Director: After th 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours

To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 4-23-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601 REVOILTIONS HAVREDE Grace MD 21078 Hetrawala mo 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

BARBARA

MCKE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 14996 State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vear Edna Toye Medical 12 10 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death LaPlata Center Charles LaPlata Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 217-32-4078 **Director** 1 M 2 XF Maryland 90 3-30-1922 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 ¥ Yes 2 □ No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code ò items 23a or ner must be n 10g. Citizen of What Country? Funeral 12140 Ell Lane Apt.202 20602 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2X No If Yes, Give Year or Dates. Saltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural" Completed 3 X Widowed 4 Divorced Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker 12 Domestic Be 17. Father's Name (First, Middle, Last) of Health and Mental Hi fitem 27 is marked ot r other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ပ Hall Elizabeth Arthur Meade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Saunders/Niece 16206 Brandywine Rd, Brandywine MD 20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ₫ <u>=</u> 1 XBurial 2 Cremation 3 Removal from State 9 Department of Important: If any injury or once. St.Marys Cath Ch 4 ☐ Donation 5 ☐ Other (Specify) 4-28-12 Bryantown Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Funeral Home, PA, Aquasco Md, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) emontia place Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: Jse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 1 ☐ Yes ∠ ⊑ g ☐ Unknown 9 Unknown signed by tel Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No I or Attending Physician: after death. Be ( funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospita Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 Accident
3 Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 💢 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number gury Secures CRU K134720 of person who completed cause of death (Item 23a) (Type, Print) CONDITION TOLOGO 4140041 Coshing Fiffary 400 Courses 31. Date filed (Mon State 5

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4 10:49 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death County of Death are Adel PRINCE Manor r 1 Year If Under 24 Hrs.

Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months (Month, Pay, Ye 22856 Director 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location event, the Medical Examiner must be notified at Director 1 Yes 2 No ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 72 hours after death Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Bace - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 If Yes, Give 1967-1969 Year or Dates 1967-1969 1 Yes 2 No Specify If Yes Give and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced BIACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည 10114 injury or other traumatic City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 1046 Hyattsville -siste 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) . Signature of Funeral Service hippnsee any FRANKLIS SH 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only of e cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine PNEUMONIA burial-transi that initiated events resulting in death) Last Due to (or as a consequence of attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate bethin 24 hours after death. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Pregnant at time of death Day Year 5 Other (specify) 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has by page 2 s autopsy After this certificate funeral director, pag 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Be Hospital: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending injury 2 🗌 No 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director: A
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, shall occurred at the time, date and clue to the cause(s) and manner stated. (Check 29d. Date signed (*Month, Day, Year*) and title of certifier 29b. Signature 29c. License number 2 AAMW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADVENTIST HOSPITAL, TAKOMA PACK SHAMIM WASHINGELD N 31. Date filed (Month, Day, Year) 32. Registr r's Sign State 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20)2 quan' Medical give street and number Facility Name (if not institution or Location of Death 4c. County of Death Examiner altmore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In 9. Birthplace (State or Foreign Funeral Days Months Hours 09/23/1947 577-78-9201 Director 1 X M 2 🗆 F 64 Ethiopia Usual Residence of Decede 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🙀 No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò with t Funeral items 23a 11421 Encore Dr. 20901 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? ö by 1 Never Married 2X Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: "natural" Completed 3 Widowed 4 Divorced **Black** Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) Civil Engineer Government and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Tarekegn Tassew Zerfe Gesesse 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tran-<u>Tsehay Ayele/Wife</u> Encore Dr. Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 04/25/2012 Brentwood, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home Signature of Funeral Service <u>3401 Bladensburg Rd. Brentwood, MD 20722</u> Raph. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Sepsis Physician. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): attending physician for use as the huris Physician/Medical death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death signed by the a g Unknown P.O. the Hospital or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 3 Probably 4 Unknown Division of Vital Records, Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy 1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certificate 1 ☐ Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? ည 1 Yes 1 Unpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural Accident injury 5 Pending Investigation filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check

only one 29b. Signature a

Victore! 31. Date filed (Month, Day, APR 2 6 2012

title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

795igg

Registrar DHMH 17 Rev 06-2011 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

wol

29d. Date signed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrin Hospice Harwood Anne Arundel Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months Hours Min (Month, Day, Year) 026-05-3250 Director 1 🛛 M 2 🗆 F 92 10/30/1919 Massachusetts show 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f Maryland Prince George's Hyattsville 1 Yes 2 1 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2203 Chapman Road 20783 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner . 10 Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married X Yes Yes, Give within 72 hours after 3altimore, Maryland 21215-0036 WWII 1 Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Completed Specify. Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Noncommissioned Officer U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o Francisco Valerio Mariana Viveiros 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or cat-Anneliese R. Valerio - Spouse 2203 Chapman Road, Hyattsville, Maryland 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 04/26/2012 Brentwood, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that cause not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each lin Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to for as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be Box 68760 as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Po in the past 12 months? Day Other (specify) Pregnant at time of death Month Year 2 No detached 9 Unknown g Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' certificate 2 🗆 No 1 Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ANDRIN မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence n 24 hours after death.

e Funeral Director; After th
bletely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Cextifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the Signature and title of co

Registrar

DHMH 17 Rev 06-2011

State

son who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 20,201<sup>Year</sup> Physician/ Vaughn April 2018 Angela Marie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) 577-94-7873 Director 1 M 2 X May 7,1960 51 Ohio Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f 1x Yes 2 No DC Washington 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö must be Funeral 20011 United States 4202 13th St., NW #102 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural" Completed 3 Widowed 4 Divorced Black Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than " Elementary/Secondary (0-12) College (1-4 or 5+) None None of Health and Mental Hygie item 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Page 1 and 2 should be rent of Health and Menta Unk. Mary Vaughn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1851 24th St., NE #T3
Washington, DC 20002
20b. Place of Disposition (Name of Date of Fayette Vaughn/sister 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. cemetery, crematory or other place) 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, MD Lincoln Mem. Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Anoxic disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the use as ding IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death ed by the ald 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, cen muscle Division of Vital Records, 1 Yes 2 No 3 Probably 4X Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? Idopathic Kypho-Scoldosos 24a. Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 102 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending n 24 hours after death e Funeral Director: A bletely filled in by the f Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor For the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 11 NOD D0071147 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carroll Are Takona

Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day, Year)

7600

MO